Virginia Department of Behavioral Health & Developmental Services

DBHDS – Frequently Asked Questions

*Indicates updated today

Contents

What to do if someone presents with COVID-19 symptoms

Group homes and residential settings

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.

Please refer to CDC's recommendations for long term care facilities settings such as nursing homes which may be applicable to group homes in which an individual has a suspected or confirmed case of COVID-19.

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

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

Q 1.2: 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?

A 1.2: 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 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 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

Licensed providers

Q 1.3: What should licensed providers do if they come in contact with an individual suspected of having COVID-19?

A 1.3: 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.

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

Sources:
http://www.vdh.virginia.gov/content/uploads/sites/13/2020/03/Provider_FAQ_03082020.pdf
http://www.dbhds.virginia.gov/assets/doc/EI/serious-incident-reporting-of-covid-19.pdf

Q 1.4: How can direct support professionals be prepared?

A 1.4: This webinar recording from the National Alliance for Direct Support Professionals has helpful information around how some COVID-19 basics and how to engage individuals with disabilities in preventive measures.

Source:
https://www.youtube.com/watch?v=ud4Q4e_hcuw&feature=youtu.be

Preventing the spread of COVID-19

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: What is the protocol for consumers who live with self-quarantined individuals who have not been confirmed to have COVID-19?

A 2.2: VDH specifies that individuals who have come in close contact with people who have confirmed cases of COVID-19 should follow these guidelines. Individuals who are at home with self-quarantined people should avoid close contact with those who are quarantined. When determining whether a service should be provided in-person, work with your agency to determine the best approach that considers the mental and physical health needs of the consumers you are serving.

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

DBHDS on-site visits

Q 2.3: Will DBHDS be limiting on-site visits to reduce the potential?

A 2.3: 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.A

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

Day support programs

Q 2.4: Should we close day support programs with fewer than 50 program participants?

A 2.4: The CDC has updated their guidelines to recommend against holding nonessential gatherings of 10 or more people. They also state "*Events of any size should only be continued if they can be carried out with adherence to guidelines for protecting vulnerable populations, hand hygiene, and social distancing.*" Providers are advised to review these guidelines and make a determination based on what they believe is in the best interest of

the population they serve and their staff; taking into account individuals with chronic medical conditions that may place them at higher risk.

Source:
https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/index.html

Social distancing and restricting visitors

Q 2.5: What is the balance between isolating individuals from programming and their mental health when the individual is not a high risk?

A 2.5: The COVID-19 situation is evolving rapidly, and conditions are changing on a daily basis. Please continue to monitor the CDC and VDH websites and work with your agency to determine the best approach to balancing the mental and physical health needs of the individuals you serve

Q 2.6: Are providers able to restrict visitors to prevent the spread of COVID-19?

A 2.6: 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 regulations allows a provider to limit visitation for all individuals in the program in order to maintain a safe environment. Please ensure appropriate notifications to individuals/authorized representatives and maintain the requirement for documentation and DBHDS oversight. Please follow updated CMS guidance to ban visitors except for end of life situations. In addition, programs serving more than 10 individuals should continue to practice social distancing and adhere to recent mandates by the President and Governor to prevent community spread.

Preventing COVID-19 among staff

Q 2.7: What should health care providers do if they come down with symptoms of COVID-19?

A 2.7: 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 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 2.8: Will providers be penalized for closing administrative offices and allowing administrative staff to telework?

Q 2.8: No. Providers should encourage telework among administrative staff whose work can be completed remotely.

Q 2.9: Are direct support professionals considered essential personnel?

A 2.9: 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

Telemedicine and providing services electronically

Q 3.1: Is it okay to conduct SIS assessments remotely?

A 3.1: 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 3.2: 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?

A 3.2: We are closely monitoring and will share more information coming soon.

***Q 3.3: Has DMAS issued guidance around telemedicine flexibility during the public health emergency.**

A 3.3: Yes, you can find more information from DMAS around use of telemedicine, including providing services via telephone, and the waiving of certain program requirements here.

Source:
https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid-memo-03-19-2020.pdf

Staffing

Pre-screeners and emergency services

Q 4.1: Should emergency services pre-screeners become compromised or quarantined, can Community Services Boards leverage other licensed clinicians on staff to complete necessary prescreens?

A 4.1: Please review guidance for CSB emergency services staff regarding this question here.

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

Q 4.2: Will alternative transportation still be available?

A 4.2: 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.

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

Transfer of direct care staff

Q 4.3: As a licensed provider, may I transfer direct care staff between licensed services based on need and staff availability?

A 4.3: 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

Q 4.4: In the event of a temporary lay-off will providers need to obtain new background checks when employees return to providing services?

A 4.4: 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.

Q 4.5: 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?

A 4.5: 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.*

***Q 4.6: What steps should we take if Fieldprint temporarily closes their office(s) in our area?**

A 4.6: It has recently come to our attention that Fieldprint has closed several of their offices throughout the Commonwealth, making it impossible for direct care staff in some areas to submit fingerprints for background checks. If a non-children's residential service provider finds themselves in an area where Fieldprint has temporarily closed its office, the provider shall take the following steps when bringing on new staff:

- Providers shall continue to require all new staff to submit a disclosure statement stating whether the person has ever been convicted of or is the subject of pending charges for any offense (12 VAC 35-105-400.B.). In addition, the provider shall address what actions it will take should it be discovered that a person has a founded case of abuse or neglect or both, or a conviction or pending criminal charge.
- Providers shall designate an employee within management to review each disclosure statement against the attached list of barrier crimes.
- Once the reviewer has completed their review, they shall sign the disclosure statement certifying that they have reviewed the disclosure statement and have not identified any barrier crimes. If the reviewer does identify barrier crimes within the disclosure statement, the employee shall not be permitted to work before the results of their criminal history background check have been returned.
- The provider shall maintain the employee's signed disclosure statement as well as the notice sent to the provider from Fieldprint stating that their local office is closed within the employee's personnel file.
- Once the abovementioned steps have been taken, if the provider allows the employee to begin working in non-children's residential licensed services prior to receipt of the employee's criminal history background check results, DBHDS will not cite providers for violation of Virginia Code §§ 37.2-416, 37.2-506, or 37.2-607.
- Please note that employees will be expected to make the first available appointment once the local Fieldprint offices re-open. Failure to do so will result in citation from the Office of Licensing.

- For individuals who previously scheduled appointments at a Fieldprint location that has since closed, Fieldprint has stated that such individuals will be contacted by its support team to reschedule at another nearby facility.

DSP Orientation and Competencies

Q 4.6: Will the requirements for DSP Orientation and Competencies be waived?

A 4.7: First, concerted effort has gone into streamlining the basic DSP competencies, so that they are more consistently applied and less time intensive to complete. We do not want to delay provider access to the streamlined version, so will be sending out to the provider community and DMAS will try to post the new forms on the DMAS website in the next week. Providers may choose to begin use of the streamlined version as soon as it is available for new hires or for existing staff or they may choose to use the existing version of the basic competencies document until DD Waiver regulations are effective.

- Next, staff who were hired within six months prior to March 12th, 2020 are reaching the end of the 180 day timeframe required for proficiency. DMAS will consider extending the date for these staff past the 180 days if documentation is on file that circumstances prevented the confirmation of proficiency during the state of emergency. This documentation should be maintained by the agency in the event of a DMAS Quality Management Review.
- It should be noted that competencies are not portable across agencies and any staff move to a new employer would be followed by the completion of competencies in the new location. The orientation training, testing, and assurances remain portable from one agency to the next.

Staffing ratios

Q 4.8: 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?

A 4.8: 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.

Services and programs

Medication

Q 5.1: Will patients be able to access their medications if non-essential healthcare visits are postponed?

A 5.1: 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/PharmacyCoronavirusInformation3-13-2020.pdf

Case management

Q 5.2: Case Management - Will the expectation for 30- and 90-day face to face case management visits during the COVID-19 outbreak be waived?

A 5.2: The 90-day face to face visits are a targeted case management requirement under CMS. This guidance from DMAS outlines how some face-to-face requirements can be waived. Information regarding developmental disability waivers starts on page 7.

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.

Source:

https://www.virginiamedicaid.dmas.virginia.gov/ECMPdfWeb/ECMServlet?memospdf=Medicaid-memo-03-19-2020.pdf

ACT programs

Q 5.3: Are there any recommendations for ACT programs?

A 5.3: Please refer to this document, which was sent directly to all ACT programs.

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

Discharge

Q 5.4: If a client discontinues services after a possible quarantine, can we pick up services afterwards as long as clinically appropriate?

A 5.4: 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.

Impact of COVID-19 on mental health

Q 6.1: What considerations should be made regarding the impact of COVID-19 on mental health?

A 6.1: The CDC has issued some guidelines regarding mental health and coping in light of the COVID-19 pandemic. In addition, please refer to guidance posted by DBHDS, The Center for the Study of Traumatic Stress, and SAMHSA with information around taking care of behavioral health during social distancing, quarantine, and isolation.

Sources:
https://www.cdc.gov/coronavirus/2019-ncov/about/coping.html
http://dbhds.virginia.gov/assets/doc/EI/covid-act-recs_3_13.pdf
https://www.cstsonline.org/assets/media/documents/CSTS_FS_Mental%20Health%20and%20Behavioral%20Guidelines%20for%20Response%20to%20%20a%20Pandemic%20Flu%20Outbreak.pdf
https://www.samhsa.gov/sites/default/files/tips-social-distancing-quarantine-isolation-031620.pdf

Face masks and personal protective equipment (PPE)

Q 7.1: How can my agency obtain personal protective equipment (PPE) for staff and clients?

A 7.1: 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 hand washing, covering coughs and sneezes, and staying home when sick.

Q 7.2: Are there alternatives that can be utilized if we are unable to obtain CDC recommended respirators?

A 7.2: 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 7.3: Do all healthcare workers need to be wearing face masks?

A 7.3: 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

Trainings

Q 8.1: Will the Office of Licensing grant at least a 3-month extension of competencies and annual training.

A 8.1: Licensing Regulation 12VAC35-105-450 requires all providers, other than children's residential providers, to develop a training policy that addresses the frequency of

retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics.

- If the provider intends to modify the frequency of retraining during this emergency period, they will need to amend their policy or create a new emergency policy to reflect this decision.
- The provider will need to provide notice to their Licensing Specialist of the policy change.
- Please note that per regulation 12 VAC 35-105-450, there shall **be at least one** employee or contractor on duty at each location who holds a current certificate (i) issued by the American Red Cross, the American Heart Association, or comparable authority in standard first aid and cardiopulmonary resuscitation (CPR) or (ii) as an emergency medical technician. A licensed medical professional who holds a current professional license shall be deemed to hold a current certificate in first aid, but not in CPR. The certification process shall include a hands-on, in-person demonstration of first aid and CPR competency. **This requirement remains during the emergency period.**
    i. Distance learning (definition: a method of studying in which lectures are broadcast or classes are conducted by correspondence or over the Internet") opportunities are continuing to grow, but for the topics and components of training that require hands on observation or competency check, they cannot not be completed via distance learning.
    ii. 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.
        1. For example, the American Heart Association (AHA) life saving training courses are available online. These courses that involve only cognitive learning can be completed entirely online. 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. The American Red Cross (ARC) has similar offerings.
    iii. 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.

DBHDS licensing regulations

Conditional licenses and renewal applications

Q 9.1: My agency is on a conditional license for community coaching, will this be extended or does the agency have to stop billing?

A 9.1: During this emergency period, the Office of Licensing will continue to process renewal applications per our March 14, 2020 correspondence.

- If your agency is on a conditional license, you should submit a renewal application. Once you submit this application, your Licensing Specialist will request for you to send additional information and documentation, as necessary in order to determine compliance with the Licensing Regulations.
- In most cases we will be able to issue a new license without an on-site visit. If your Licensing Specialist determines a new license cannot be issued without conducting an on-site review, we will handle these situations on a case-by-case basis.

Communication with DBHDS

Q 9.2: What kinds of changes do DBHDS-licensed providers need to notify the Office of Licensing about?

A 9.2: 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

Q 9.3: 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?

A 9.3: Only providers licensed by the DBHDS Office of Licensing are required to enter incidents into CHRIS. Please review this guidance regarding when to report cases of COVID-19 in CHRIS.

If DBHDS licenses the unit of the hospital where the condition was identified, or the individual received treatment, the hospital will need to enter the incident into CHRIS as a Level II Serious Incident.

Q 9.4: 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?

A 9.4: No. The Office of Licensing is deeming 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.

Q 9.5: What is the intended outcome/goal of reporting these cases in CHRIS?

A 9.5: The goal is for DBHDS to be able to monitor the ongoing situation regarding COVID-19 infections and potential hotspot areas to where additional resources may be necessary.