DBHDS – Frequently Asked Questions

Contents

What to do if someone presents with COVID-19 symptoms

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

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

Source:

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

Q 1.2: 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

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

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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

Q 2.3: What additional steps is DBHDS taking to reduce the potential exposure of program staff or individuals receiving services?

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

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 large gathering of 50 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/mass-gatherings-ready-for-covid-19.html

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.

Home health

Q 2.6: How should home health aides monitor or restrict home visits for health care staff?

A 2.6: Health care providers who have signs and symptoms of a respiratory infection should not report to work. Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:

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

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

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

Preventing COVID-19 among staff

Q 2.8: Can we ask new or current employees about their recent travel?

A 2.8: Local agencies should continue to follow human resources policies set forth by respective human resource departments, and those policies should be consistent with the "*The U.S. Equal*

Employment Opportunity Commission; Pandemic Preparedness in the workplace and the Americans with Disabilities Act."

Q 2.9: When an employee returns from travel during a pandemic, must an employer wait until the employee develops flu-like symptoms to ask questions about exposure during the trip?

A 2.9: No. These would not be disability-related inquiries. If the CDC or state or local public health officials recommend that people who visit specified locations remain at home for several days until it is clear they do not have pandemic influenza symptoms, an employer may ask whether employees are returning from these locations, even if the travel was personal.

Q 2.10: Are there ADA-compliant ways for employers to identify which employees are more likely to be unavailable for work in the event of a pandemic?

A 2.10: Yes. Employers may make inquiries that are not disability-related. An inquiry is not disability-related if it is designed to identify potential non-medical reasons for absence during a pandemic (e.g., curtailed public transportation) on an equal footing with medical reasons (e.g., chronic illnesses that increase the risk of complications). The inquiry should be structured so that the employee gives one answer of "yes" or "no" to the whole question without specifying the factor(s) that apply to him. The answer need not be given anonymously.

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

EXAMPLE - ADA-COMPLIANT PRE-PANDEMIC EMPLOYEE SURVEY
Directions: Answer "yes" to the whole question *without specifying the factor that applies to you*. Simply check "yes" or "no" at the bottom of the page.
In the event of a pandemic, would you be unable to come to work because of any one of the following reasons:

- If schools or day-care centers were closed, you would need to care for a child;
- If other services were unavailable, you would need to care for other dependents;
- If public transport were sporadic or unavailable, you would be unable to travel to work; and/or;
- If you or a member of your household fall into one of the categories identified by the CDC as being at high risk for serious complications from the pandemic influenza virus, you would be advised by public health authorities not to come to work (e.g., pregnant women; persons with compromised immune systems due to cancer, HIV, history of organ transplant or other medical conditions; persons less than 65 years of age with underlying chronic conditions; or persons over 65).

Answer: YES_____ , NO_____

Source:

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

Q 2.11: Will providers be penalized for closing administrative offices and allowing administrative staff to telework?

Q 2.11: No. Providers should encourage telework among administrative staff whose work can be completed remotely.

Q 2.12: Are direct support professionals considered essential personnel?

A 2.12: 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

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Telemedicine and providing services electronically

Q 3.1: What guidance is there for licensed providers around the use of telemedicine services as a way to mitigate risk and limit exposure to COVID-19?

A 3.1: We do not yet have any updated guidance on the use of telemedicine services and reimbursement for them in place of face to face visits.

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

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

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

Q 3.2: In the case of services that can be provided remotely via phone or electronically, is there a protocol for screening patients who may have contracted COVID-19?

A 3.2: If you are able to provide a service remotely, and the individual to whom you are providing that service is presenting with flu-like symptoms, it may make sense to provide that service via the phone or electronically. Make sure to adhere to guidelines set forth by the Equal Employment Opportunity Commission.

Source:

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

Q 3.3: Is it okay to conduct SIS assessments remotely?

A 3.3: Yes, SIS assessments may be conducted via video call or other electronic means. During the assessment, the assessor should make sure to be in a secure room (without others entering and exiting), and the individual being assessed should also be advised to be in a place that affords privacy.

Q 3.4: Can waiver-related therapeutic consultations be completed using video conferencing?

A 3.4: We are working closely with our partners at the Department of Medical Assistance Services (DMAS) to provide further guidance on this. We will share more information shortly.

Q 3.5: Will the Office of Licensing allow flexibility within Sponsored Residential providers to provide oversite through video or telephone if an extension is needed beyond 3 months?

A 3.5: At this point, the Office of Licensing is not ready to say this will be permissible, as we do not know how long the Commonwealth will need to have increased precautions related to COVID-19. We will continue to monitor the situation, and will make adjustments and allowances as needed over the next several weeks.

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.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.

Therapeutic day treatment (TDT)

Q 4.3: Can licensed office/clinic staff supplement the school day for therapeutic day treatment (TDT) services until further notice?

A 4.3: We are working closely with our partners at the Department of Medical Assistance Services (DMAS) to provide further guidance on this. We will share more information shortly.

Transfer of direct care staff

Q 4.4: As a licensed provider, may I transfer direct care staff between licensed services based on need and staff availability?

A 4.4: 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 4.5: In the event of a temporary lay-off will providers need to obtain new background checks when employees return to providing services?

A 4.5: 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 4.6: 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 4.6: 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.**

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, and we are working with our partners at DMAS around what the federal expectations for these visits will be.

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

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

Q 5.4: In response to the licensing memo section regarding service modifications, the Virginia Sponsored Residential Provider Group requests that the Department of Licensing allow the following actions to continue without an onsite inspection by the Office of Licensing:

A 5.4: Sponsored homes which are already licensed and may be moving locations during this time:

i. This action would require for the provider to submit a service modification and for the Licensing Specialist to conduct an on-site review of the proposed site. Per my March 13, 2020 correspondence, the Office of Licensing is limiting service modifications requiring an on-site visit only to those that are in response to an immediate need for expansion of services due to the emergency at hand. This policy protects individuals served by our licensed providers as well as provider and Licensing staff by minimizing the risk of exposure to infectious diseases.

- Sponsored homes which are already licensed in one location and are in the process of purchasing a new home?
  i. Please see answer above.
- Sponsored homes which are already licensed and have just purchased a new home?
  i. Please see answer above.
- Would be a new sponsored home under a provider agency with a Triennial License but started the process to become licensed prior to March 14 and have a Service Modification already submitted to be added to the Provider Agency but were awaiting a visit from a licensing specialist?
  i. Please see answer above.

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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 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

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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 had 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

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REACH programs

Q 8.1: How can REACH programs limit staff and individuals' potential exposure to COVID-19?

A 8.1: REACH is a program designed to mitigate the risk of psychiatric and psychological crisis. As such this is a critical service to ensure the safety of the individuals supported particularly during a pandemic that has the potential to increase anxiety of the individuals were serve, their families, and staff. Staff should take all precautions outlined through the Virginia Department of Health and the CDC when responding to individuals in crisis to mitigate risk of contracting any communicable disease and always engage in behaviors that are indicative of training related to universal precautions. Additionally, staff should adhere to any protocols established by the programs or emergency rooms that they are responding to ensure that they do not inadvertently spread a communicable disease.

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

Q 8.2: Are there options for requesting an alternative site for our intervention and can video conferencing be used (this is in particular related to hospital responses) for REACH?

A: 8.2: Crisis intervention/stabilization are core functions of the REACH program and critical to ensuring that individuals are supported through increased anxiety as a result of altered schedules and pandemic related fears. All staff should follow the precautions outlined through the CDC, VDH and the place where they are responding (hospitals, etc.). DBHDS is working on guidance about when a telehealth response is appropriate. This will be forthcoming and will align with expectations of emergency services.

Q 8.3: What are the "essential" services for REACH so that we can ensure that each program prioritizes staffing and that it is consistent across state?

A 8.3: Crisis services are essential services. Prevention services are not essential at this time and should be completed telephonically or through secure video chat.

Q 8.4: What are the best practices for when/how to support folks in crisis who are symptomatic without increasing our staff's risk?

A 8.4: Best practices for mitigating risk are posted on VDH website as well as the CDC website. If an individual is not in active crisis. Staff should minimize contact with any symptomatic individual.

Q 8.5: Should REACH be providing services in homes where people are presenting with symptoms?

A 8.5: REACH should follow best practice guidelines for screening related to COVID-19 and limit contact when appropriate, particularly if the individual is not in an active crisis but the service is preventative in nature.

Q 8.6: Should REACH be responding to ERs? Will hospital consults by phone / telemedicine vs in person be permitted?

A 8.6: Crisis intervention/stabilization are core functions of the REACH program and critical to ensuring the support of individuals who may be experiencing increased anxiety as a result of altered schedules and pandemic related fears. All staff should follow the precautions outlined through the CDC, VDH as well as the location where they are responding (hospitals, etc.). DBHDS is working on guidance about when a telehealth response is appropriate. This will be forthcoming and will align with expectations of emergency services.

Q.8.7: Will REACH be permitted to cap our community therapeutic home (CTH) census if staffing shortage becomes critical?

A 8.7: CTH programs should utilize best practices strategies as outlined for residential type providers on mitigating and containing the spread of communicable diseases. This includes staff remaining at home if they are ill or have been exposed to coronavirus. At this time, we will not be capping admissions to the program but can discuss and review this as needed depending on the status at the home.

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Trainings

Q 9.1: Will DBHDS take measures to offer trainings via computer or extend compliance deadlines?

A 9.1: As the situation evolves, DBHDS will be considering cancelling large group trainings or conducting them electronically. With respect to required competency-based trainings for direct support and other staff, all efforts to conduct training to protect health and safety should be made. If you require additional guidance specific to training your staff, please email Stephanie Waite (stephanie.waite@dbhds.virginia.gov) to request additional clarification.

Q 9.2: Will the Office of Licensing grant at least a 3 month extension of competencies and annual training.

A 9.2: 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.

Communication with DBHDS

What changes and updates do I need to alert the Office of Licensing about?

As always, 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.