Maryland
DEPARTMENT OF HEALTH

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

To: **DDA Participants**
**Coordinators of Community Services**
**Fiscal Management Services Providers**
**Support Brokers**
**DDA Providers**
**Developmental Disabilities Administration Staff**
**Eligibility Determination Division**
**Office of Health Care Quality**

From: **Robert R. Neall, Secretary**

Re: **COVID-19 #16: DDA Waivers Programs Telehealth and Telephonic Guidance**

Release Date: **April 13, 2020**

Effective: **March 13, 2020**

**NOTE: Please ensure appropriate staff members in your organization are informed of the contents of this memorandum.**

**Background**

On March 5, 2020, Governor Lawrence J. Hogan, Jr., declared a state of emergency due to disease ("COVID-19") caused by the novel coronavirus. The COVID-19 outbreak was declared a national emergency on March 13, 2020 and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The measures outlined in this document are restricted to use during the emergency declared by Governor Hogan related to the threat of COVID-19 and will expire immediately at the end of the declared emergency or when revised by additional orders such that the Secretary's authority to issue this guidance no longer exists.

The actions outlined below are taken pursuant to the authority vested in the Secretary of Health by the laws of Maryland, including but not limited to Sections 18-102 and 18-103 of the Health-General Article of the Maryland Annotated Code and Executive Order No. 20-04-01-01.

The actions apply to both the self-directed and traditional service delivery models for the following programs (the "Programs"):

- The Developmental Disabilities Administration's (DDA) Medicaid 1915(c) Waiver programs:
    - Family Supports Waiver;
    - Community Supports Waiver; and
    - Community Pathways Waiver; and
- DDA's State Funded Program.

This guidance is effective immediately and shall remain in effect until further notice.

**Overview**

The health care and safety of participants and Medicaid providers is a priority during the COVID-19 State of Emergency. To prevent transmission and spread of COVID-19 disease, the Maryland Department of Health (the "Department") is allowing certain services covered under these Programs to be delivered either by phone or through telehealth applications.

This document addresses the following:

1. General Guidance: Delivery of Services by Phone or Via Telehealth;
2. How to Screen Participants and Staff Before Conducting a Face-to-Face Visit;
3. Eligibility, Assessment, and Monitoring Activities;
4. Documenting Signatures; and
5. Services that Must be Delivered Face-to-Face.

This guidance applies to all individuals providing direct services, oversight, monitoring, coordination, investigations, and other **actions** for any of the aforementioned Programs. This includes direct support professionals, provider program and management staff, coordinators of community services, support brokers, and State representatives (*i.e.*, Developmental Disabilities Administration and Office of Health Care Quality staff). It is designed to promote the safety of both the participants and families and the individuals performing program related tasks, while allowing vital services to be delivered. **Before making an in-person visit, a determination should be made regarding whether the goals of the visit can be satisfied using remote technology in place of an in-person visit**.

**1. General Guidance: Delivery Services by Phone or Via Telehealth**

Whenever possible, individuals are encouraged to deliver services by phone or telehealth. A subset of services that must continue to be provided face-to-face are addressed in Section 5. Under no circumstances should phones or other telehealth technology be used to assess a participant for a medical emergency.

When appropriate, services can be delivered through telehealth using a real-time audio-visual connection that allows the staff member to both see and hear the participant. Personal care services that only require verbal cueing (the ability to hear a verbal response from the participant) can also be delivered by phone.

Individuals providing direct services, oversight, monitoring, coordination, investigations, and other program actions who are not able to meet in-person with a participant should make every effort to use the following technology, in order of priority:

1) Traditional telehealth technology which meets all formal requirements pursuant to 10.09.49.
2) If participants are unable to access originating sites possessing fully qualified technology (ability to pan/focus camera, multiple views, etc.) this emergency policy will permit the use of notebook computers or smartphones.
3) If participants cannot access any video technology, audio-only telephone calls will be permitted.

- ***Note:*** Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers. If providers choose to continue to use Zoom, they must use the password feature and make all individuals aware of the issue outlined above.

  Each web-based service has advantages and limitations and your agency should determine what works best for your situation. In selecting a virtual format, we strongly recommend that you consider:

  · Security vulnerability – is the platform encrypted?
  · Confidentiality – will confidentiality be maintained during meeting?
  · Accessibility – will that platform be accessible for all abilities?
  · Reliability – confidence in the ability to provide the service when agreed upon?
  · Connectivity quality – will your agency be able to handle the connections?
  · User friendliness – will platform be easy to use or understand by all involved?
  · Affordability – is it free or not a financial burden to your agency or the participant, as the Department will not reimburse for such services?

Programs may use the phone or telehealth to engage in activities such as eligibility, case management (*i.e.*, Coordination of Community Services), evaluations, initial and annual level of care determinations, staff meetings, and development and monitoring of person-centered plans. Examples of interactions where use of the phone or telehealth is permitted are listed immediately below. This list is not exhaustive. When determining if a service can be safely delivered by phone or telehealth, individuals should use their best judgement and make decisions that are in accordance with CDC, Department, and clinical guidance.

- Participant and family consultations;
- Supervision of direct care staff;
- Provision of: (1) Nurse Consultation; (2) Nurse Health Case Management; and (3) Nurse Case Management and Delegation;
- Annual, quarterly, or monthly visits previously conducted face-to-face;
- Required team meetings;
- Case management services, including application assistance;
- Meaningful Day Services and Support Services, such as Personal Supports and Family and Peer Mentoring;
- Staff training, if possible and appropriate; and

- Other services as addressed in Section 2.

If Nursing or Behavior Services staff perform visits by phone or via telehealth instead of face-to-face, they should respond to all communication from participants and/or their representative and residential providers within 24 hours. The individuals providing direct services, oversight, monitoring, coordination, investigations, and other program actions must document all communication in the participant's record. With appropriate participant consent, the individual must be in contact with the other appropriate Program providers, other involved providers (*e.g.,* including Community First Choice, REM), informal supports, and family members to ensure adequate and sufficient supports are in place.

All other requirements regarding documentation, maintenance of participant records, and other program operations continue to apply. Self-directed services staff and Provider staff must continue to comply with other Office of Health Care Quality (OHCQ) and Maryland Board of Nursing (MBON) requirements and guidance.

## 2. How to Screen Participants and Staff Before Conducting a Face-to-Face Visit

While some Program services can be delivered effectively by phone or via telehealth, in certain instances, face-to-face contact may still be clinically indicated and may be a life safety issue. Two screenings should be conducted before a face-to-face visit is conducted: (A) screening of participants; and (B) screening of the person conducting the visit. Results of these screens and whether the service was provided should be documented in the participant's record.

### (A) Screening of Participants and their Household Members Before a Face-to-Face Visit

All individuals conducting the visits should contact the participant **one hour prior** to the face-to-face and/or home visit (unless an immediate emergency) and ask if anyone in the household:

1. Has fever, cough, shortness of breath, nausea, vomiting, or diarrhea;
2. Is currently sick with COVID-19 or the flu; OR
3. Has been told by a health provider that they should not have visitors due to illness.

If the participant screens positive in response to any of these questions, the individual conducting the site visit should ensure that the person has been referred to the appropriate health care provider and coordinate next steps with the participant, their guardian or legally authorized representative, other appropriate staff and care providers. If the participant or household member appears to be seriously ill, encourage the participant to contact the primary care provider or, if necessary, to call 9-1-1.

If the participant has an immediate need for services that must be delivered face-to-face, the individual conducting the face-to-face and/or home visit should take appropriate measures to ensure service needs are met and to safeguard the health, safety and welfare of the participant. The individual conducting the site visit should follow CDC guidance regarding precautions for conducting face-to-face visits. See Section 5 of this document for links to these resources.

If the participant has immediate health care management needs, for example, the participant requires assistance with pharmacy or accessing food and other basic needs, then the individual

conducting the site visit should assure a frequency of contact sufficient to keep the participant healthy and safe.

If the participant does not screen positive in response to any of these questions, the face-to-face visit may proceed at the discretion of the individual conducting the site visit and with the consent of the participant, subject to the result of the screening discussed in subsection (B) below.

**(B) Screening of Individual Conducting Site Visit Before a Face-to-Face Visit**

Individuals conducting visits should also be screened each day before working together in-person and before entering the location or participant's home for a face-to-face visit. Participants and Program providers must strictly enforce practices and policies prohibiting staff showing symptoms of illness to remain at work or visit participants. Staff should only return to work after a period of isolation and without symptoms.

Screening should include the following elements:

**i. Temperature**

Individuals conducting site visits must do a self-temperature check at least once a day. If temperature reading exceeds 100.4°F [38°C], staff should **NOT** conduct home visits/face-to-face services and should report their status to their supervisor.

Individuals conducting visits must also check their temperature prior to providing in-person face-to-face services.

**ii. Screening**

Staff should be screened using the following questions prior to either: (1) reporting to an in-person office; or (2) any face-to-face visit. Staff should indicate if anyone (including themselves) in the staff member's household:

- Has fever, cough, shortness of breath, nausea, vomiting, or diarrhea;
- Is currently sick with COVID-19 or the flu; or
- Has been told by a health provider that they should not have visitors due to illness.

If a positive response to these screening questions is provided, the provider agency should not allow the staff to come to the office or perform home or site visits. The staff person should contact their primary care physician immediately or be referred to immediate medical care, if indicated. **3. Eligibility, Assessment, and Monitoring Activities**

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**(A) Reassessments for Continued Program Eligibility during the State of Emergency**

Participants who were eligible for DDA and Waiver services as of March 1, 2020 will continue to be eligible until March 1, 2021. The Department will not be re-determining continued eligibility for services during the State of Emergency.

**(B) Performance of Required Assessments and Monitoring Activities; Permitted Extensions**

Although eligibility will be extended, monitoring assessments should be conducted by phone or via telehealth whenever possible to ensure participants receive the appropriate level of services.

Information regarding "significant changes" can also be collected by phone or via telehealth and should be documented in participants' records appropriately. Additional guidance regarding increases or changes to Person-Centered Plans or annual budgets under Self-Directed Services delivery model for permitted services will be issued separately.

The following assessments and monitoring activities should be conducted by phone or via telehealth whenever possible for the DDA programs.

| **Mandatory Assessments and Monitoring Activities** | **Frequency** |
|---|---|
| Level of Care (LOC) | Initial<br>Annual<br>As Needed |
| Person-Centered Plan | Initial<br>Revised<br>Annual<br>Emergency Revised |
| Health Risk Screen Tool | Initial<br>Annual<br>As Needed |
| Support Intensity Scale | Initial |
| Community Setting Questionnaire | Initial<br>Annual<br>As Needed |
| Nurse Assessments | In accordance with Maryland Board of Nursing Guidance on Modifications to COMAR 10.27.11 Requirements during State of Emergency |
| Behavioral Assessments | As Needed |

| | |
|---|---|
| CCS Monitoring and Following | Quarterly<br>As Needed |

If extenuating circumstances prevent completion of any of the above activities in a timely fashion, the participant's eligibility for services will not be impacted. Extensions must be documented by the responsible person or entity. HRST and Nursing services need to also be reported to the DDA. Any contact with participants and providers to discuss extension should be included in this documentation.

**(C) Eligibility Evaluation and Initial Level of Care Evaluations for New Participants**

Initial eligibility assessments should continue to be performed during the State of Emergency by phone or via telehealth. All requirements related to timeframes, signatures, as well as documentation and record retention continue to apply. Options for collecting signatures are addressed in Section 4.

**4. Documenting Signatures**

During the State of Emergency, Programs are not required to have Program participants and/or their authorized representatives, providers, and DDA Staff physically sign documents in-person. Signatures can instead be collected in the following ways.

**(A) Electronic signature**

**(B) Submission of an Attestation by mail, PDF or photograph**

1) Individual may sign and date a paper with the following statement written or printed on it:

   "I, (insert name of Person/authorized representative/service provider/etc.), have reviewed (Name of Document) on (insert reference date) and agree to its content."

2) A copy of the signed piece of paper should be sent to the Program:
   a) By mail
   b) Electronically:
      - As a PDF – paper should be scanned and submitted electronically, e.g., by e-mail or text
      - As a photograph – a legible picture of the statement, signature, and date taken and submitted electronically, e.g., by e-mail or text.

The flexibility provided by the Centers for Medicare and Medicaid (CMS) services currently does not allow for verbal consents. If CMS updates its policy, the Department will align its requirements as well.

**5. Services that Must be Delivered Face-to-Face**

Certain services can only be provided on a face-to-face basis. Providers and direct support staff should continue to deliver these services during the State of Emergency as long as they can be provided in a manner that is safe for both the staff and the participant.

Direct support staff should comply with current safety guidance issued by the Centers for Disease Control and Prevention (CDC) and the Maryland Department of Health regarding delivery of services in-person.

**Additional Resources**

- CDC: https://www.cdc.gov/coronavirus/2019-ncov/index.html
- Maryland Department of Health, Department of Budget Management: https://dbm.maryland.gov/employees/Pages/COVID19.aspx
- See "Guidance for Home Visiting Staff" under Information for State Agencies
- For Medicaid-related Coronavirus updates, visit mmcp.health.maryland.gov.
- For questions about the Coronavirus, visit coronavirus.maryland.gov.
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
- DORS - Guidance on the Use of Teleconferencing to Provide Services https://dors.maryland.gov/crps/Documents/CRP_teleconf_guidlelines.pdf
- DDA Covid-19 dedicated resource page: https://dda.health.maryland.gov/Pages/DDA_COVID-19_Information.aspx