



# Behavioral Health and Developmental Disabilities Administration

Communication #20-02

## Guidance for Specific Clinically Essential Face to Face Encounters in Behavioral Health Clinics, Substance Use Services and Residential Settings in the COVID-19 Context

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[Guidance for Michigan Department of Health and Human Services For Community Based Mental Health Services, Substance Use Services and their Providers Practicing in Clinical Settings and Delivering Home Based Services](#)

*Updated as of 3/22/20*

The following guidance regarding prevention of the spread of the Coronavirus Disease of 2019 (COVID-19) pertains to the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration public and private organizations, entities, authorities, and providers who work directly with persons served in behavioral health and substance use disorder (SUD) community-based settings. This guidance is based on the recommendations from the Centers for Disease Control and Prevention (CDC) and MDHHS. All individuals are encouraged to use resources available at [www.michigan.gov/coronavirus](http://www.michigan.gov/coronavirus), including posters to raise awareness of steps that can be taken. This website is being updated continually.

### **Guidance for Specific Behavioral Health Services and Supports and Determinations of the Need for Essential Face to Face Encounters for Individuals Served in Mental Health Clinics, SUD services and Residential Settings**

Although there is currently a priority to provide clinical support for individuals via telephonic, video, or other virtual connections to minimize the spread of COVID-19, there will be cases in which a clinical face to face, in-person encounter is needed to appropriately assess an individual in need of care related to a behavioral health concern. Staff should be mindful of making decisions as to who will need face to face assessment or intervention that requires proximity to a person within the social distance standards (6 feet apart), including physical contact with the individual served (e.g., blood draws, checking for

medication side effects through physical examination, delivering injections of medications).

The CDC defines close contact as follows:

- CDC definition of a close contact\*:

**a) being within approximately 6 feet** (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

-OR-

**b) having direct contact** with infectious secretions of a COVID-19 case (e.g., being coughed on)

\*if such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, N95 respirator or facemask, and eye protection), the contact is considered an exposure.

### **Clinical Considerations for General face to face encounters:**

Decisions for whether a person who shifts from the usual face to face, in-person encounter to a telephonic, or other virtual encounter as a result of COVID-19 should be done with clinical guidance, recognizing the public health directive to maximize social distancing and utilize telepractice type care delivery. However, for someone who would otherwise have a face to face, in person encounter, the clinical rationale (both from an infection control and a behavioral health perspective) must be documented. Clinical decisions should be based on the behavioral health needs of the person. In addition to their behavioral health needs, the risk to the person receiving BH services poses for spreading the COVID-19 virus or for contracting it must be considered when evaluating the need for a face to face clinical assessment. The need for face to face vs virtual encounters should be evaluated regularly according to the needs of the person and the public health directives, which can change over time. Such decisions should be made with the liberal use of clinical consultation with community mental health, PIHP, or provider medical directors and other clinical supervisors.

*Also, face to face encounters that can be conducted using social distance standards (avoiding close contact) should be conducted utilizing this practice.*

### Guidelines for Home Visits in the Behavioral Health Context

When preparing or scheduling appointments for home-based visits (e.g, ACT services, ABA services, or other types of face to face services), please use the following guidance to ensure the safety of the staff and the person served:

- Visits should be pre-scheduled whenever possible to gather information about the person's clinical condition, both from a behavioral health perspective and from a physical health perspective.
- When scheduling a visit or prior to entering a home, staff should ask the following three screening questions pertaining to all household members:
  1. Is there any reason you have been instructed to self-quarantine or isolate? If yes, why?
  2. Have you had contact with any Persons Under Investigation (PUIs) for COVID-19 within the last 14 days, OR with anyone with confirmed COVID-19?; and
  3. Do you have any symptoms of a respiratory infection (e.g., cough, sore throat, fever, or shortness of breath)?

Staff are expected to complete a face to face encounter if the answer to all three questions is “no” from all members of the residential setting. Staff should be sensitive to the fact that a member of the residential setting, including the person being served, may not be comfortable with you entering the home (they may be concerned about you exposing them) and the visit should be rescheduled if possible. If wellness checks are needed, a visit by some personnel may still need to occur. A visit to a residence should be rescheduled if answers to any of the screening questions change between scheduling and the time the visit occurs. The visit to the residence should be rescheduled if any residents in the residential setting indicate a reason for self-quarantine or isolation.

**Guidance if Individuals are Presenting Behavioral Health and Safety Concerns During the COVID-19 Crisis**

Consultation with a clinical supervisor is advised if the behavioral health needs of the individual raise separate health and safety concerns distinct from the health and safety concerns related to COVID-19. It is recommended that individuals served and their families work out a crisis management plan in the event that there is escalated risk of COVID-19 related issues or if there is escalated risk of behavioral health emergencies during the COVID-19 crisis. Such plans should be done in consultation with providers. If in-person contact cannot occur, staff should utilize any and all other available resources to make contact with the individual being served, including but not limited to phone calls, skype, facetime, or other technology that allows verification of the individual’s safety and the ability to address concerns about the individuals well-being.

**Guidance for an Individual who is reasonably believed to be a Person Requiring Treatment with and without COVID-19 symptoms, history or elevated COVID-19 risk due to exposure:**

A petition for certification by a Community Mental Health Services Program (CMHSP) should be completed if there is a reasonable basis to believe that an individual may need psychiatric hospitalization as a person requiring treatment. Although unrelated to the issues pursuant to a petition, given the risk of exposure of others who might encounter the respondent to the petition, the petition should be accompanied by information on COVID-19 status of the individual, if known.

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