



**Behavioral Health and
Developmental Disabilities Administration**

Communication #20-08

Frequently Asked Questions Regarding COVID-19 for Licensed Psychiatric Hospitals (LPH)s

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For Questions Please Contact:

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Q1:

How do you implement social distancing on a psychiatric unit?

R1:

Programming must balance the psychiatric needs and the medical needs pertaining to COVID-19. To the extent possible, social distancing should be maintained. This may mean a shift in group schedules and sizes, use of larger rooms as available, and shifts in how meals are served to minimize close contact. There should be ongoing education of patients and staff regarding safe practice to mitigate viral spread.

Q2:

What do we do if a person becomes symptomatic with COVID-19 like symptoms and has either not been tested or the test results aren't available yet? Is it reasonable to transfer to medical when they are a "person under investigation" for COVID-19?

R2: Psychiatric units should develop protocols for management of both asymptomatic persons and persons who develop COVID-19-like symptoms. These protocols should include increased monitoring and management of both staff and patients based COVID-19 status issues. Protocols for management of symptomatic patients should include identifying when to transfer patient to medical services. These protocols should be in accordance with CDC guidelines.

Q3:

Can we use isolation or seclusion to maintain social distancing?

R3:

The Executive Order to maintain social distancing, which is the current legal standard, allows for services to be provided face to face that are necessary to preserve life and safety, and this includes providing for psychiatric hospitalization when clinically indicated.

Seclusion used in psychiatric hospitals, isolation, and quarantine are not equivalent concepts and are not operationalized in the same way. Isolation in the COVID-19 context involves the

separation of people who are known to have a contagious condition.

Quarantine is the separation of individuals who are suspected of having a contagious condition that could infect others. Seclusion is utilized in authorized psychiatric settings when an individual exhibits behavioral dysregulation that creates an imminent risk of harm to self and others and does not respond to less restrictive interventions.

The Michigan Mental Health Code (MHC) Chapter 7, Administrative Rules and CMS guidance as well as specific hospital policies should guide decisions on when seclusion is indicated. Note that although CMS issued guidance loosening the rules on seclusion, Michigan specific laws and rules have not been relaxed, and therefore continue to apply. Hospitals should continue to examine situations on a case by case basis and utilize seclusion in those clinical circumstances where criteria are met for seclusion as they were prior to COVID-19. Patients with COVID-19 or who have been identified as a Person Under Investigation (PUI) should isolate or quarantine to rooms or areas of the hospital/unit separate from others to the extent possible. As noted in Question 2, hospitals should develop protocols to maximize the safety of all patients and mitigate the spread of the virus to other patients. Creative measures, such as temporary barriers between sections of unit to help separate patients that have difficulty staying within their room, is encouraged. Procedures and locations to allow isolation or quarantine in accordance with CDC guidelines should be in place to address the likelihood that COVID-19 will impact psychiatric units.

Q4:

With CDC guidelines highlighting the importance of face masks, what should hospitals do related to masks for patients on psychiatric units?

R4:

Psychiatric hospitals should be following CDC guidelines regarding PPE, as well as guidelines for all persons to have face coverings when individuals are within six feet of another person. Patients should be encouraged to voluntarily wear face coverings or masks as part of hospital protocol. If the masks themselves create risks for individual patients (e.g., ligature risks, contraindicating medical conditions), then a case by case determination should be made regarding the use of such a mask with a patient. In addition, masks on inpatient psychiatric units should be inventoried closely.

Q5:

How can we maximize interaction with the psychiatrist for our patients?

R5:

The amount and scope of the services provided by the psychiatrist after admission should be based on the Individual Plan of Service and that should be updated if clinical condition changes. Even if a patient is court ordered, person-centered planning is required to be done in partnership with the patient. If a patient is not satisfied with the amount or scope of services provided, then the IPOS should be reviewed and amended if necessary.

Each psychiatric hospital or unit should also have Medical Staff Bylaws or policies that establish the requirements of the medical staff. It may not specifically state how much contact is required with patients but should require enough time/1:1 contact, etc. to ensure treatment plans and required care is provided. In the COVID-19 context, it might be prudent to review with the Medical Director and update as needed. In addition, some patient interactions might be facilitated if done by video engagement and this should be considered as an option to augment but not supplant, and only as allowed by CMS, hospital bylaws, and policies related to psychiatric access.

Q6:

What happens if a patient requests a jury trial?

R6:

Administrative Order 2020-10, effective April 23, 2020, delays all jury trials until June 22, 2020 or until further order of the court. As such, patients, guardians and their counsel should be reminded of this Judicial Order.

https://courts.michigan.gov/Courts/MichiganSupremeCourt/rules/court-rules-admin-matters/Administrative%20Orders/2020-08_2020-04-23_FormattedOrder_AO2020-10.pdf

Q7:

Do you need consent to test for COVID-19 in a psychiatric hospital or unit?

R7:

This is a topic of ongoing discussion that will continue to evolve with new public health mandates and orders.

Currently, consent is required for testing. When a person is asked to submit to a COVID-19 test, it is important to remember that adults of sound mind are permitted to refuse medical procedures. Proper informed consent needs to include an explanation of the risk of such refusal and the benefits of the intervention. Similarly, psychiatric patients are presumed competent, and therefore should be allowed to refuse as well, presuming their decision-making is sound. If a patient has impaired decision-making, based on an appropriate clinical assessment, a legally authorized decision-maker (e.g., a guardian or parent) should be consulted and may consent on behalf of the assenting patient. Without assent, even with a substitute decision-maker, the risks and benefits of the procedure may not lead to a lifesaving or a perfect result. Mandatory, involuntary testing has risks of its own. Testing may have false positive and false negative results and results should be interpreted within a broader clinical context. Precautions must still be taken to protect others if an individual refuses testing, and these precautions should be developed, in light of, whether the person is asymptomatic with no known COVID-19 exposure, symptomatic or a person under investigation. There should be ongoing education and dialogue with the patient over time regarding COVID-19, the value of testing and virus risk reduction precautions, while treating the psychiatric illness.

Reviewed by: Behavioral Health COVID-19 Response Team (BHCRT): Jeffery Wieferich, Larry Scott, Belinda Hawks, Kim Batsche-McKenzie, Jody Lewis, Price Pullins, Jon Villasurda, Leslie Asman, Raymie Postema, Dr. Debra Pinals, Allen Jansen

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Signatures:

The image shows two handwritten signatures in blue ink. The first signature is "Allen Jansen" and the second is "Debra A. Pinals".