

Maryland Behavioral Health Coalition

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April 14, 2020

The Honorable Larry Hogan
Governor of Maryland
100 State Circle
Annapolis, MD 21401

Governor Hogan –

Thank you for your continued efforts to combat the spread of coronavirus in Maryland, and to ensure that all Marylanders have access to needed health and behavioral health services during the COVID-19 crisis. The ferocity of this disease is unlike anything we've ever seen, and the impact is being borne disproportionately by Marylanders living and working in congregate settings.

As you have recognized, congregate settings present the most difficult challenges during this public health emergency. Your recent actions to protect nursing home residents and staff will undoubtedly have a positive effect in those particular locations, but there are many other similarly situated facilities that must be taken into account. State psychiatric facilities, residential rehabilitation programs, residential crisis and substance use treatment programs, residential treatment centers for youth, group homes, assisted living facilities, correctional facilities – all have vulnerable populations and staff living and working in close quarters making them more susceptible to infection and death.

In an effort to prevent and slow the spread of coronavirus in congregate settings throughout Maryland, and to address concerns specific to these facilities, the undersigned organizations of the Maryland Behavioral Health Coalition offer the following recommendations for your consideration.

TARGETED TESTING AND OBSERVATION

Individuals entering or being transferred or discharged from congregate settings – whether as residents, arrestees or otherwise – must be tested for coronavirus before they are allowed to mix with the broader population. For those already living in these settings, facilities should identify people at particular risk for infection and develop plans to reduce the risk. This includes individuals at risk due to age, pre-existing health conditions, and those unwilling, unlikely or unable to comply with appropriate precautionary policies.

All congregate care facilities should have a process for monitoring symptoms of staff and those receiving services. Further, your directive related to nursing homes should be expanded to require that *all* congregate settings have separate areas, to the extent possible, where newly admitted and readmitted individuals are observed for signs and symptoms of the disease, and designated areas to care for individuals with known or suspected COVID-19.

STRATEGIES TO REDUCE UNNECESSARY USE OF CONGREGATE SETTINGS

We agree with recommendations offered by faculty of the Johns Hopkins Bloomberg School of Public Health for reducing spread of coronavirus in jails and prisons, including limiting pretrial

detention when possible and expediting parole for older incarcerated individuals and those with chronic conditions predisposing them to severe COVID-19.

Further, state psychiatric facilities should identify and expedite discharge of individuals who are voluntary, not dangerous, competent and/or non-restorable, and who are able to be served in the community, by family or otherwise. In cases where family members are willing to care for loved ones but lack the necessary resources, the state should provide those families with financial support in line with the costs of providing care in an institution or community setting. Importantly, individuals discharged from facilities to home or another temporary setting should not lose priority status for residential rehabilitation, DDA-funded residential services, subsidized housing, or any other benefit that prioritizes support to folks moving from an institution to the community.

Additionally, the Maryland Court of Appeals should be encouraged to issue standards and guidance that ensures the safety of staff and patients while maintaining due process rights for individuals with psychiatric conditions. Competency hearings, psychiatric evaluations and uncontested hearings related to criminal responsibility are being held with less frequency in courts across the state, forcing many to remain in congregate settings for much longer than necessary. Criminal competency hearings should be held remotely whenever possible or disposed of without a hearing in uncontested cases. Discretion to postpone in-person court-ordered evaluations should be limited and used primarily in situations where there is inadequate personal protective equipment (PPE) for evaluators or when the individual remains symptomatic from known or presumed COVID-19.

SUPPORT FOR STAFF

Residents in congregate settings are not the only ones at risk. Frontline staff at these institutions put themselves at risk every day to ensure vulnerable Marylanders have the health and support services they need to lead safe and fulfilling lives. We must ensure these essential caregivers are protected with the resources and supports they deserve.

The trauma and emotional toll of working in these settings during the crisis cannot be overstated. As more residents and the staff themselves become sick, those left to carry the weight are faced not just with overly burdensome workloads but also with fear and concern for their own health, safety and well-being. Congregate settings across the state should be encouraged to provide emotional support, therapy and trauma training for their employees. A recent funding opportunity announced by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) anticipates this need, requiring at least 10% of any direct services provided under the grant to be used for workers who need mental health treatment as a result of COVID-19.

Staff working in congregate care settings are often among the lowest paid employees of health care organizations. The state should look to leverage federal funding to support salary increases for frontline workers. The Families First Coronavirus Response Act includes a temporary 6.2% increase in federal matching rates for Medicaid programs. Consideration should be given as to whether that funding increase could be used to provide 'hazard pay' for staff in congregate settings.

Additionally, Maryland should increase options for staff reluctant to go home during the crisis for fear of potentially spreading illness to their families. Initiatives at hotels and universities across the country are providing rooms and lodging for medical professionals who need a place to sleep,

recharge, or isolate from their families. The state should encourage Maryland institutions to provide this service for all staff working in congregate settings.

Lastly, while we are aware of the widespread shortage of PPE nationwide, these materials are essential for staff in congregate settings. Maryland must prioritize distribution of PPE to folks working in these facilities.

OPTIONS FOR FAMILIES

The challenges of congregate living in this time of crisis extend not just to the residents themselves, but also to the families who have seen restricted access to relatives during the state of emergency. There is no shortage of heartbreaking stories detailing tragic situations in which family members have been prevented from remaining with their loved ones during their final days and hours.

Maryland should take the steps necessary to facilitate connections between family/friends and loved ones living in congregate settings. Socially distanced outdoor meetings and virtual visits should be allowed where feasible. Additionally, liability waivers should be considered when family members or close friends are willing to assume the risk of entering congregate settings (with PPE) to visit with relatives.

INCREASE OVERSIGHT OF POTENTIAL ABUSE AND NEGLECT

Sadly, mistreatment of individuals in congregate settings does not vanish during a state of emergency. Stressful work environments and competing priorities may actually lead to more instances of abuse and neglect. Maryland should issue directives to congregate facilities to decrease the likelihood of such occurrences, including orders limiting the use of segregation and seclusion among non-exposed/healthy individuals and guidance to ensure people confined to their rooms are not isolated without activities or other stimulating opportunities. Congregate care settings should be required to utilize video monitoring and recording where such systems are available, and to store digital recordings for future review, as necessary. Further, the state should publicize how individuals in congregate settings, staff and others can report instances of abuse or neglect.

PURSUE ALL FEDERAL HEALTH FUNDING OPPORTUNITIES

We appreciate your attention to these recommendations. We believe they are essential to ensuring the safety of those living and working in the settings most at-risk during the COVID-19 emergency. We understand these suggestions are not without cost. However, as you are undoubtedly aware, the federal Coronavirus Aid, Relief and Economic Security (CARES) Act provides the state with a variety of funding options that could be used to offset some of the expenses. These include:

- \$425 million for behavioral health services, including \$100 million for emergency response spending that can target support to where it is needed most;
- \$17.4 billion in housing resources, including \$15 million for Section 811 housing for persons with disabilities, \$1.25 billion to preserve Section 8 vouchers for seniors, the disabled and low-income working families, and \$5 billion that can be used flexibly to address COVID-19 housing challenges;
- \$19.6 billion for veterans' services, including resources to expand mental health services delivered via telehealth; and

- \$1 billion for criminal justice-related needs, including medical care, tests and supplies for prisons, jails and detention centers

Again, thank you for your consideration. We know you are juggling multiple pressing priorities, but we feel the suggestions above are critical to Maryland's COVID-19 response effort.

Sincerely,

Adventist HealthCare Behavioral Health
Arundel Lodge
Baltimore City Substance Abuse Directorate
Baltimore Crisis Response, Inc. (BCRI)
Baltimore Harm Reduction Coalition (BHRC)
Baltimore Jewish Council (BJC)
Behavioral Health System Baltimore (BHSB)
Brain Injury Association of Maryland (BIAMD)
Catholic Charities of Baltimore
Chesapeake Voyagers
Community Behavioral Health Association of Maryland (CBH)
Cornerstone Montgomery
Disability Rights Maryland (DRM)
Eastern Shore Behavioral Health Coalition
Health Care for the Homeless (HCH)
Horizon Foundation
Key Point Health Services
Legal Action Center
Maryland Association of Resources for Families and Youth (MARFY)
Maryland Association for the Treatment of Opioid Dependence (MATOD)
Maryland Chapter, American College of Emergency Physicians (ACEP)
Maryland Clinical Social Work Coalition
Maryland Coalition on Mental Health and Aging
Maryland Nonprofits
Maryland Psychiatric Society (MPS)
Maryland Psychological Association (MPA)
Maryland Rural Health Association (MRHA)
Mental Health Association of Maryland (MHAMD)
Mid Shore Behavioral Health
National Alliance on Mental Illness (NAMI) Maryland
National Council on Alcoholism and Drug Dependence (NCADD) Maryland
On Our Own of Maryland
Sheppard Pratt Health System

cc: Sam Abed, Secretary, Maryland Department of Juvenile Services
Carol Beatty, Secretary, Maryland Department of Disabilities
Robert L. Green, Maryland Department of Public Safety and Correctional Services
Rona E. Kramer, Secretary, Maryland Department of Aging

Robert R. Neall, Secretary, Maryland Department of Health

George W. Owings III, Secretary, Maryland Department of Veterans Affairs

Lourdes R. Padilla, Secretary, Maryland Department of Human Services

Aliya Jones, M.D., Deputy Secretary, Behavioral Health, Maryland Department of Health

Dennis R. Schrader, Deputy Secretary, Health Care Financing and Chief Operating Officer,
Maryland Department of Health

Bernard Simons, Deputy Secretary, Developmental Disabilities, Maryland Department of
Health