



Guidance for Providers of Home and Community Based Services Operating Under Contract with the New Jersey Department of Children and Families

March 24, 2020

As a result of the COVID-19 pandemic, DCF is working to relax usual operating requirements to permit flexibility that preserves quality of service for clients while promoting the ability of both clients and service providers to adhere to necessary social distancing practices. These guidelines are **effective immediately**. Circumstances are changing rapidly, and additional guidance will be released as needed.

Please note this guidance does ***not*** apply to providers of out-of-home programs (e.g., congregate, residential, shelter), CSOC Individual Support and Respite Services, visitation or supportive visitation services. DCF will issue separate guidance regarding these services.

- 1. The following DCF services may be delivered using remote technology during the COVID-19 emergency.**

Child Protection and Child Welfare Service Providers

- Keeping Families Together
- Homemaker services
- Family Preservation Services
- Providers of mental health outpatient services, outpatient substance use disorder treatment services, psychological and psychiatric evaluations
- Providers of in-home or community-based services, such as parenting support and education, case management, services for adolescents and young adults in foster care (e.g. PACES, life skills, and aftercare), etc.

Children's System of Care Providers

- Family Support Organizations
- Providers of cost-reimbursement contracted mental health outpatient and partial care services, and outpatient substance use disorder treatment services

Early Childhood and Family and Community Support Service Providers

- Evidence-Based Home Visiting (Nurse Family Partnership, Healthy Families America Parents as Teachers, Home Instruction for Parents of Preschoolers)
- Family Success Centers
- Kinship Navigator Services
- Family Friendly Centers
- School Based Services
- Outreach to At-Risk Youth (OTARY)

Division on Women Programs (Sexual Violence, Domestic Violence, Prevention, and Displaced Homemaker Services)

- Advocacy
- Case management
- Counseling
- Crisis intervention
- Legal services
- Children’s Services [Peace: A Learned Solution [PALS], Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)]
- Sexual Assault Response Team (SART) response --refer to guidance from Office of Attorney General for any changes to SART standards
- Displaced Homemaker Program
- 24/7 Hotline and Referral services (Domestic violence and sexual violence) - Can be done remotely if providers are able to reroute calls to cell phones

2. Licensed clinicians are expected to adhere to applicable laws and regulations in provision of tele-health services

The New Jersey Telemedicine Act lays out standards for provision of telemedicine services, issuance of prescriptions via telemedicine services, and payment for services. Additionally, state boards have issued proposed regulations for various licensed professionals including psychologists, psychoanalysts, social workers, and nurses.

On March 19, 2020, Governor Murphy signed legislation expanding access to telehealth services. For the duration of the public health emergency, any healthcare practitioner is authorized to provide and bill for services using telehealth to the extent appropriate under the standard of care. Providers should ensure that the services patients receive using telehealth are appropriate, medically necessary, and meet current quality of care standards.

3. Telehealth methods are acceptable methods of delivering certain services within the Children’s System of Care.

The NJ Department of Human Services has issued [telehealth guidance](#) that applies to the delivery of physical and behavioral health care. As a result of these changes to the usual operation of the state’s Medicaid-funded services, the following applies to Children’s System of Care services:

- Care Management Organizations – Services delivered via the bundled monthly rate, and services delivered on a fee-for-service basis may be delivered using tele-health approaches provided that such approaches comply with applicable law, applicable regulation, and guidance provided by the NJ Department of Human Services, Division of Medical Assistance and Health Services including the March 21, 2020 Newsletter, which is enclosed here as Appendix C.
- Mobile Response and Stabilization Services - Mobile Response and Stabilization Services may be delivered using remote technology, provided that that such approaches comply with applicable law, applicable regulation, and guidance provided by the NJ Department of Human Services, Division of Medical Assistance and Health Services including the March 21 2020 Newsletter, which is enclosed here as Appendix C. In addition, the NJ Department of Children and Families has issued specific guidance for screening and dispatch decision making. (Mobile Response and Stabilization Services Dispatch Guidance, March 22, 2020)

• Intensive In-Community Services and Intensive In-Home Behavioral and Clinical Services Intensive In-Community Services and Intensive In-Home Behavioral and Clinical Services may be delivered using remote technology, provided that that such approaches comply with applicable law, applicable regulation, and guidance provided by the NJ Department of Human Services, Division of Medical Assistance and Health Services including the March 21 2020 Newsletter, which is enclosed here as Appendix C.

4. Standards of care for provision of remote services

Combined audio/visual technology is the preferred method of remote service delivery. When that is not available, use of audio only is acceptable. Standards of care for provision of remote services are provided in Appendix A. Additional standards of care applying to Domestic and Sexual Violence Services are included as Appendix B.

Providers who intend to use remote service delivery methods must submit to DCF, an attestation of your organization’s adherence to these Standards. DCF’s business offices will be sending Attestation Forms and detailed instructions regarding submitting attestations during the week of March 23, 2020 and providers will be expected to submit their attestation by April 6. A template of the required attestation is included as Appendix C. The DCF business offices will send provider-specific templates, including contract numbers and programs, to each provider beginning the week of March 23.

Questions regarding the Standards of Care or attestation process should be submitted to askdcf@dcf.nj.gov.

Appendices:

Appendix A: Standards of Care for Remote Service Delivery

Appendix B: Virtual Domestic and Sexual Violence Services Best Practices Addendum

Appendix C: Attestation Template: Adherence to Standards of Care

Appendix D: DMAHS March 21, 2020 Newsletter

Appendix A

Standards of Care for Remote Service Delivery

The American Telemedicine Association, American Psychiatric Association, American Psychological Association, American Academy of Child and Adolescent Psychiatry, and others have issued clinical, technical and administrative guidelines and best practices for the provision of mental and behavioral health services using electronic communication [1-7]. Key clinical guidelines are detailed below:

I. General

- a. Verification of identity and location: At the beginning of remote session, the following details must be verified and/or documented: provider and client identity; provider and client contact information; provider and client location; and expectations for contact between the provider and client in-between sessions [5].
- b. Client's appropriateness for remote services: The provider must determine whether the client is appropriate for remote services with or without professional staff immediately available.
 - i. If the service is delivered by a licensed clinician or an individual working under the supervision of a licensed clinician, assessing whether the client is appropriate for Remote Service Delivery should also include a determination of the appropriate setting for service delivery (e.g., home-based, professionally supervised) – including an assessment of the client's distance to the nearest emergency medical facility, support system, clinical status, and competence with technology. Providers should also consider whether there are clinical aspects of the patient's care requiring in-person examination [1,3,5].
- c. Informed consent: An informed consent process should be undertaken and documented with the client in real-time at the start of services and comply with local, regional and national laws.
 - i. If the service is delivered by a licensed clinician or an individual working under the supervision of a licensed clinician, informed consent should include all information relevant to in-person care in addition to information specific to telemental health services (e.g., limits of confidentiality when communicating electronically) [10]. It should include all information relevant to in-person care in addition to information specific to telemental health services (e.g., limits of confidentiality when communicating electronically) [5].
- d. Physical environment: The professional and client environment should be comparable to the standard provided as part of in-person services. Visual and auditory privacy should be ensured, lighting and seating should maximize the client's comfort, and technology and lighting should be adjusted to maximize the visibility of the client, provider, and other participants in care [3,4,5].
- e. Collaboration and coordination of care: With client consent, providers should arrange for regular, private communication with other professionals involved in the client's care [6,7].
- f. Emergency management: Emergency management should be considered for supervised and unsupervised settings. Providers should be familiar with the laws related to involuntary hospitalization and duty-to-notify in the client's jurisdiction, familiar with client's access to transportation in the case of an emergency, and aware of local emergency services. When

services are provided outside of the client's home (e.g., in a clinic or school), the provider should become familiar with the facility's emergency management procedures or, as needed, coordinate with the facility to establish basic procedures. When providing services in a setting without immediately available professional staff, the provider should request contact information for a family or community support person to be called on in case of an emergency [5].

- g. Medical issues: If the service is delivered by a licensed clinician or an individual working under the supervision of a licensed clinician the provider should be familiar with the patient's prescription and medication dispensation options as well as the availability of specific medications where the patient is located [5].
- h. Referral resources: If the service is delivered by a licensed clinician or an individual working under the supervision of a licensed clinician, the provider should be familiar with available local, in-person mental health resources should he or she need to refer the patient to additional or alternative mental health services [5].
- i. Management of client-provider relationship: The provider should have clear policies in place around communication with clients, including appropriate sharing of content via different technologies, response times, and boundaries [1].
- j. Cultural competency: Providers should be familiar with the culture and environment in which the client is situated, should assess the client's prior exposure to and familiarity with the technological mode of service delivery, and be aware of how these factors could affect treatment interactions between the client and the provider [1,3].

II. Special Considerations for Children and Adolescents

- a. Procedures for evaluation and treatment of youth via electronic communication should consider the developmental status of youth (e.g., speech capability, motor functioning) [1].
- b. The child or adolescent's physical environment should facilitate assessment (e.g., adequate room size, simple toys and activities). The size of the room should be large enough to accommodate one or more adults and movement of the child. Some settings may not be appropriate for assessment and treatment of youth (for example, hostile home environments) [3,4,6].
- c. Participation of adults in the delivery of their child's remote services should generally adhere to standard in-person practices however, modifications may be needed. For example, an in-person "presenter" may be needed to help assist with rating scales, collecting vital signs, managing the child, etc. Families with a maltreatment history may not be appropriate for remote services delivered in an unsupervised setting (e.g., home) [1,4]. Additionally, parents should be assessed for their ability to safely participate in and/or supervise telemedicine sessions for their children. [3,4].

III. Special Considerations for Providers of Domestic Violence and Sexual Violence Prevention and Intervention Programs

When using virtual services for survivors of domestic and sexual violence, survivor safety and confidentiality considerations remain paramount. National Technical Assistance Providers have provided comprehensive guidance to help providers shift to virtual services swiftly, during this public health emergency, while still ensuring compliance with confidentiality and privacy provisions required by the Health Insurance Portability and Accountability Act (HIPAA), Violence Against Women Act (VAWA) and Family Violence and Prevention Services Act (FVPSA). See Appendix B which covers equipment, digital platforms, informed consent, and survivor-centered processes for the delivery of services.

Additional Resources

- American Telehealth Association: <https://www.americantelemed.org/>
- Mid-Atlantic Telehealth Resource Center. “Telebehavioral Health Center of Excellence”. <https://tbhcoe.matrc.org/>
- NASWNJ. Tips for Understanding the NJ Telemedicine/Telehealth Law: Implications for the Practice of Social Work. Accessed from: https://cdn.ymaws.com/www.naswnj.org/resource/resmgr/clinical_sw/Telemedicine-Telehealth_Law_.pdf
- Northeast Telehealth Resource Center. <https://netrc.org/>

Citations

1. American Psychiatric Association & American Telemedicine Association. (2018). Best Practices in Video-Conferencing based Telemental Health. Accessed from: <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-and-ata-release-new-telemental-health-guide>
2. American Psychological Association. (December, 2013). Guidelines for the Practice of Telepsychology. Accessed from: <https://www.apa.org/pubs/journals/features/amp-a0035001.pdf>
3. American Academy of Child and Adolescent Psychiatry. (2017). Clinical Update: Telepsychiatry with Children and Adolescents. Accessed from: https://www.aacap.org/App_Themes/AACAP/Docs/clinical_updates/telepsychiatry_with_children.pdf
4. American Telemedicine Association. (March, 2017). Practice Guidelines for Telemental Health with Children and Adolescents. Accessed from: <https://tbhcoe.matrc.org/wp-content/uploads/2018/07/ATA-Children--Adolescents-Guidelines-2017.pdf?189db0&189db0>
5. American Telemedicine Association Telemental Health Practice Guidelines Workgroup. (2013). Practice Guidelines for Video-Based Online Mental Health Services. Accessed from: <https://www.integration.samhsa.gov/operations-administration/practice-guidelines-for-video-based-online-mental-health-services ATA 5 29 13.pdf>

6. American Telemedicine Association. (2009). Evidence Based Practice for Telemental Health. Accessed from: https://www.unmc.edu/bhecn/_documents/evidence-based-telemental-health-with-cover.pdf
7. Yellowlees P, Shore J, Roberts L. (2010). Practice guidelines for videoconferencing-based telemental health - October 2009. *Telemed J E Health*. 16 (10): 1074-1089.
8. National Association of Social Workers, Association of Social Work Boards, Council on Social Work Education, and Clinical Social Work Association. (2017). Standards for Technology in Social Work Practice. Accessed from: https://www.socialworkers.org/includes/newIncludes/homepage/PRA-BRO-33617.TechStandards_FINAL_POSTING.pdf

Appendix B: Virtual Domestic and Sexual Violence Services Best Practices Addendum



Virtual Domestic and Sexual Violence Services Best Practices Addendum

Note: Many of these practices/standards are adapted from the National Network to End Domestic Violence's Technology Safety

Website: <https://www.techsafety.org/https://www.techsafety.org/resources>

Best Practice 1: Prioritize Safety and Security:

General Information: Minimize the risks related to using digital platforms; update safety and privacy planning protocols to educate survivors about those risks; protocols should include helping survivors make informed choices about their use of each platform, and strategies to help them safety plan and about how to minimize the storage of sensitive information on their devices or accounts.

- **With phone communication:** Make sure it is safe to call a survivor and ensure they are in a private place; allow them to call back if needed; leave a vague message, if needed; let them know when is a good time to call you back; if a call is dropped, ask survivors ahead of time if they would like to call you back, or you call them back; manually dial *67 before you dial the number of the survivor, if possible, although some survivors may reject blocked numbers. <https://www.techsafety.org/resources-agencyuse/phone-communication-bestpractices>

As you may be using cell phones to communicate with survivors during this pandemic: Advocates should use program provided cell phones if possible to ensure safety and security; location sharing should only be on with the consent of advocate; don't save survivor contact info in the phone; all incoming and outgoing calls should be purged regularly. <https://www.techsafety.org/resources-agencyuse/cell-phone-bestpractices>

- **With text:** Use data encryption services; try to use only service provided cell phones; survivors could download a specific app if possible; create appropriate staff boundaries; more than one advocate may be required for text-based communication; clarify points or statements if confusion (<https://kaofeng-lee-s90t.squarespace.com/text-best-practices>).
- **With chat-based services:** check with safety and minimize interception; let survivors know what will happen when you end the conversation (if chat-based services will go down); do not allow chat-based services to be saved or copied; ensure survivors of their choices and limit confidential information; ensure data security through encryption (<https://www.techsafety.org/chat-best-practices>).

Limit apps' access to the device's location, contacts, and other potentially sensitive information

- **With video:** Use a combination of video and audio if video cuts out; develop a plan of action if a call is dropped; advocates should only use organization issued devices; talk with survivors about the safety of their surroundings; check-in if they continue to feel comfortable with video conferencing, if continual; identify interpreters as needed; assure secure and encrypted services (<https://kaofeng-lee-s90t.squarespace.com/video-best-practices>).
- The list below includes some vendors that represent that they provide HIPAA-compliant video communication products and will enter into a HIPAA Business Associate Agreement <https://www.jotform.com/blog/best-hipaa-compliant-video-conferencing-software/>
 - Skype for Business
 - Updox
 - VSee
 - Zoom for Healthcare
 - Doxy.me
 - Google G Suite Hangouts Meet
 - RingCentral

Please also see additional Information: *Enforcement discretion for telehealth remote communications during COVID-19* from U.S Department of Health and Human Services <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>) especially: “Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without the risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications. Under this Notice, however, 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”

Checklist when using mobile devices <https://www.techsafety.org/resources-agencyuse/mobilecomputing-bestpractices>:

- Do not use personal devices for work purposes.
- Do not mingle personal and professional data on the devices, particularly if professional data includes survivor information.
- Do put a passcode on the device.
- Do install security updates and download anti-malware protection on all devices.
- Do review the privacy and security settings on the device and in each app.

- Do not use public Wi-Fi if accessing client information or other sensitive information. Instead, use a secure network or VPN to connect with the office or to share files. Also, consider using a secure cloud-based file-sharing system.
- Do only download apps that are necessary for work.

Best Practice 2: Clear Communication

Check in to make sure that what you are communicating is not being misinterpreted, as this can be difficult without seeing body language from both the survivor or advocate; avoid automated responses by text or chat services, and slang or emojis; for interpretation, utilize multilingual advocates of live interpreters.

Best Practice 3: Protect Privacy by Collecting Minimal Information:

As necessary, turn off platforms that collect incidental data that can be personally identifying; data collection policies should be the same whether speaking face to face, through text, etc.; collect only as much information as necessary.

Best Practice 4: Provide quality digital services:

Determine how and when you share information to the survivor about their rights, confidentiality, mandatory reporting, and other information, as you would normally do; this should be done at the start of the conversation before too much information is shared.

Best Practice 5: Survivors have the right to make informed choices:

- Be clear with survivors when services are available; if it is 24/7 or within a specific time frame, specify that information upfront; provide notices of wait times if survivors need to wait for a survivor; possibly provide video, text, chat, or phone availability to ongoing clients; provider choice.
- Create protocols for staff to ensure they know how to proceed if a survivor drops from the call.

Best Practice 6: Plan for the unexpected:

Plan to let survivors know if your services are completely down due to unforeseen circumstances.

Additional Information:

Health systems are open during this public health emergency, so this should be communicated to survivors (<https://cdn.ymaws.com/www.forensicnurses.org/resource/resmgr/docs/COVID-19.pdf>):

Communicate to patients seeking treatment after abuse that the healthcare system is open and safe for them to access.

Other tips on sexual violence response in disaster

https://www.nsvrc.org/sites/default/files/Publications_NSVRC_Guides_Sexual-Violence-in-Disasters_A-planning-guide-for-prevention-and-response.pdf)

- Alert responders/advocates about the possibility that disasters may cause re-traumatization of sexual assault survivors and that they may need counseling from rape crisis or other specially trained professionals or volunteers.
- Ensure documentation is kept in a secure location.

Additional Resources

Link to Telehealth informed consent:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=fN67-dWQReM%3d&portalid=0>

Other:

- <https://naswnj.socialworkers.org/News/COVID-19-FAQ-Resources>
- <https://www.americantelemed.org/>
- <https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf>
- <https://netrc.org/>
- <https://naswnj.socialworkers.org/News/COVID-19-FAQ-Resources>
- https://cdn.ymaws.com/www.naswnj.org/resource/resmgr/clinical_sw/Telemedicine-Telehealth_Law_.pdf
- https://www.nsvrc.org/sites/default/files/Publications_NSVRC_Guides_Sexual-Violence-in-Disasters_A-planning-guide-for-prevention-and-response.pdf
- <https://www.yumpu.com/en/document/read/39636813/toolkit-with-report-form-pennsylvania-coalition-against-domestic->
- <https://www.techsafety.org/digital-services-during-public-health-crises>
- <https://www.futureswithoutviolence.org/get-updates-information-covid-19/>
- <https://vawnet.org/news/preventing-managing-spread-covid-19-within-domestic-violence-programs>
- <https://vawnet.org/materials/disaster>
- <https://www.nctsn.org/resources/parent-caregiver-guide-to-helping-families-cope-with-the-coronavirus-disease-2019>
- https://nnedv.org/latest_update/resources-response-coronavirus-covid-19/
- <https://www.futureswithoutviolence.org/get-updates-information-covid-19/>
- <https://www.ena.org/practice-resources/COVID-19>
- <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- <https://njcedv.org/>
- <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/checklist.html>
- <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/practice-preparedness.html>
- <https://vawnet.org/sc/response>

Appendix C

Attestation Template: Adherence to Standards of Care

By my signature below, I hereby attest that I am authorized to sign this document on behalf of my organization and agree my organization will implement the Standards of Care for Remote Service Delivery, and as applicable, the Virtual Domestic and Sexual Violence Services Best Practices for the DCF contracted programs listed:

{DCF WILL INSERT A LIST OF SPECIFIC PROGRAMS FOR EACH PROVIDER}

Signature Date

Printed Name, Title

Appendix D: [DMAHS March 21 2020 Newsletter](#)