

ACBH FAQs: Clinical Documentation Updates During the COVID-19 Nationwide Public Health Emergency

August 18, 2020 Update (UPDATES Q1 – 23)

All of these FAQs apply to both Mental Health (MH) and Substance Use Disorder (SUD) Services during the COVID emergency period, unless otherwise indicated.

For Questions & Technical Assistance, contact: QATA@ACgov.org

Principles:

ACBH recognizes that COVID-19 presents a myriad of challenges. ACBH is working collaboratively with Department of Healthcare Services (DHCS), providers, and other stakeholders to ensure we continue to provide access to care and services, while also minimizing the spread of COVID-19.

Q1: How can providers maintain services in the face of staff shortages? (Update)

DHCS anticipates that staff illness and quarantine may create challenges for provider organizations. DHCS encourages providers to do contingency planning to ensure that clients are able to access needed care. DHCS provides specific guidance in the [COVID-19 Behavioral Health Information Notice 20-009](#).

Q2: (SUD only) During the emergency, can the county waive a county requirement for a minimum number of hours of clinical services for residential treatment? (NEW)

Yes. County-specific requirements can be waived as long as all DHCS requirements are met.

ACBH SUD Residential 3.1, 3.3 and 3.5 services must meet the minimum DHCS claiming standards of:

- five (5) clinical service hours per week, and
- 15 minutes of daily service activity (clinical or non-clinical) per day, with some services being provided in-person, and on-site, weekly in order to claim for RES services.

Q3: (SUD only) During the emergency, are there any flexibilities for the DMC-ODS to reduce the Progress Note frequency requirements? (NEW)

No. There are no flexibilities for the progress note requirements.

Q4: During the emergency, may the timeline requirements for processing, issuing and logging grievances, appeals, and Notices of Adverse Benefit Determination (NOABDs) be modified? (NEW)

No. There are no changes or flexibilities regarding the counties' and providers' responsibility for NOABD timelines. DHCS is not considering revisions to the NOABD timelines at this time. The exception granted was to extend the beneficiaries timelines to request grievances and appeals. As such, the exception is a temporary modification allowing beneficiaries an extra 120 days in addition to the standard 120 days to request a State Fair Hearing (for a total of 240 days). For more detailed information please see [BHIN 20-011](#).



- Q5: During the emergency, will DHCS revise the timeline requirement for requests for service (timely access)? (NEW)**
No. DHCS is no longer pursuing this flexibility.
- Q6: During the emergency, there have been provider reductions in staff and capacity. Do providers have to report provider changes to ACBH? (NEW)**
Yes. All such requirements as indicated in the ACBH Provider Contract must continue to be met and the provider must immediately alert their contract monitor liaison.
- Q7: (SUD only) During the emergency, will there be any additional flexibilities for the DMC-ODS required hours for Intensive Outpatient Treatment (IOT)? (NEW)**
No. The requirements for Intensive Outpatient Treatment services are not changed and DHCS will no longer seek a waiver regarding this.
- Q8: (SUD only) During the emergency, if a county that has opted into the DMC-ODS waiver has closed a facility or no longer accepts clients due to physical distancing, is the county required to offer the same type of modality at another site? (NEW)**
Yes. Counties must meet network adequacy standards, thus, if a DMC-ODS facility/provider location closed or limited its capacity to practice physical distancing the provider must immediately alert their Contract Monitor. The county must provide all medically necessary services at another location and/or via telephone and telehealth.
- Q9: Is it acceptable to use the place of service code 02 in a telehealth claim for DMC-ODS services and specialty mental health services? (Update)**
Yes. The place of service code 02 (telehealth modifier) is acceptable for services that may be provided through telehealth for both DMC and SMHS services. For more details see the SMHS billing manual and BHIN 20-009 for DMC ODS.
- Q10: (MH only) For individuals placed on a 5150 hold and in the ER, is it permissible for the professional person in charge of a Crisis Stabilization Unit (CSU) or their designee to conduct an assessment via telehealth prior to admission to the CSU, so that the professional person in charge or their designee can be counted as part of the required staffing ratio at the CSU? (NEW)**
No. The assessment is not allowable via telehealth and must be in-person pursuant to Welfare and Institutions (W&I) Code section 5151, "Prior to admitting a person to the facility for treatment and evaluation pursuant to Section 5150, the professional person in charge of the facility or his or her designee shall assess the individual in-person to determine the appropriateness of the involuntary detention."
- Q11: How can behavioral health providers obtain personal protective equipment (PPE)? (Update)**
Resources on infection mitigation in behavioral health facilities are as follows: California Department of Public Health (CDPH) and DHCS co-published [Infection Mitigation in Behavioral Health Facilities](#)



- [ASAM's Infection Mitigation in Residential Treatment Facilities](#), which provides helpful information on the same, designed for SUD residential treatment
- National Council on Behavioral Health [COVID-19 guidance for behavioral health facilities](#)

Q12: (MH only) What SMHS can be provided to a beneficiary before his or her client plan is approved? (NEW)

Prior to the client plan being approved, the following SMHS and service activities are reimbursable:

- Assessment
- Plan Development
- Crisis Intervention
- Crisis Stabilization
- Medication Support Services (for assessment, evaluation, or plan development; **or if there is an urgent need**, which **must** be documented)
- Targeted Case Management and Intensive Care Coordination (ICC) (for plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services.

Q13: (MH only) When is a beneficiary's signature required on a client plan? (NEW)

The beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan when:

- The beneficiary is expected to be in long-term treatment as determined by the MHP; and, the client plan provides that the beneficiary will be receiving more than one type of SMHS; and/or
- The MHP documentation standards require it.

When a beneficiary's signature or the signature of the legal representative is required, but the beneficiary refuses to sign the client plan or is unavailable, the MHP shall ensure the client plan includes a written explanation of the refusal or unavailability (MHP Contract; Cal. Code Regs. tit. 9, § 1810.440(c)(2)).

Q14: The Director of the California Department of Consumer Affairs has temporarily waived some legal requirements for certain individuals seeking to renew a license or registration pursuant to Division 2 of the Business and Professions Code, including suspending some exam and continuing education requirements. Has DHCS issued any guidance for providers who hold a license or registration issued by the Board of Behavioral Sciences (BBS) that is set to expire? (Update)

No. BBS, however, has issued FAQs on this issue. These FAQs can be found [here](#). Licensees/registrants have until September 30, 2020, to take and pass any required exams and/or to complete any continuing education requirements. DHCS will consider an individual's license/registration valid during the extension such that the individual can continue to engage in the full scope of practice as allowable by law.

Q15: (SUD only) Can DHCS allow the county and providers to bill Medi-Cal and receive payment for ongoing SUD services, even if a residential level of care is not medically necessary or the client has hit the maximum length of stay permitted by DMC-ODS, until such time that an appropriate discharge plan



can be put in place for recovery residence, shelter, or other safe housing and the provider documents efforts to transition client to an outpatient level of care? (NEW)

No. Counties and providers cannot bill Drug Medi-Cal or DMC-ODS when extending treatment due to the public health emergency if no medical necessity for treatment exists.

Q16: Where are up-to-date resources on COVID-19?

1. [Medicaid.gov COVID-10 resource page \(NEW\)](#)
2. [California Department of Public Health – COVID-19 Updates CDPH](#)
3. [Alameda County Health Care Services Agency Public Health Department](#)
4. [Gathering/Meeting Guidance](#)
5. [CDC COVID-19 webpage](#)
6. [Guidance for the Elderly](#)
7. [Guidance for Employers](#)
8. [What to do if you are sick](#)
9. [Guidance for Workplace/School/Home Document](#)
10. [Steps to Prevent Illness](#)
11. [Guidance for use of Certain Industrial Respirators by Health Care Personnel Medicaid.gov, COVID-19 resource page](#)
12. [CMS: Emergency Medical Treatment and Labor Act \(EMTALA\) Requirements and Implications](#)
13. [Governor Newsom's 3/12/20 Order](#)
14. [CDPH: For Individuals with Access and Functional Needs](#)

Q17: How should behavioral health programs reduce transmission of COVID-19? (Update)

The CDC has provided interim [infection prevention and control recommendations](#) in health care settings.

Q18: How should behavioral health providers manage clients presenting with upper respiratory symptoms? (Update)

DHCS strongly encourages use of telehealth or telephone services to minimize infection spread. When telehealth is not available, providers should develop procedures to minimize the risk that symptomatic clients will infect staff or other clients. clients with a cough should wear a mask if available.

Programs should follow infection prevention and control recommendations in health care settings [published by the CDC](#).

Q19: When should programs refer a client to medical care? (Update)

There is currently no treatment for COVID-19, only supportive care for severe illness. Mildly symptomatic clients should stay home. See CDC guidelines for health care professionals on when clients with suspected COVID-19 should seek medical care.

Q20: (SUD only) What should SUD facilities do in the event a client is diagnosed with COVID-19? (Update)

If a client of an outpatient facility is confirmed to be positive for COVID-19, the client should be instructed to stay home. Services may be provided by telephone or telehealth. Residential or inpatient facilities with a client or resident diagnosed with



COVID-19 should ensure the client is isolated in a room, has a mask for use when leaving the room, and should contact their local public health department for guidance. Inpatient and residential facilities must also report to DHCS, within one (1) working day, any events identified in California Code of Regulations Title 9 Chapter 5 Section 10561(b)(1), which would include cases of communicable diseases such as COVID-19.

Q21: If a former client is later found to have been diagnosed with COVID-19, what action should be taken? (Update)

Staff should inform possible contacts of their possible exposure but must protect and maintain the participant's confidentiality as required by law. Clients exposed to a person with confirmed COVID-19 should refer to CDC guidance on how to address their potential exposure, as recommendations are evolving over time.

Q22: (SUD only) What should SUD facilities do in the event a staff member is diagnosed with COVID-19? (Update)

Staff members who have symptoms of a respiratory illness should stay home until symptoms have completely resolved. Staff members with confirmed COVID-19 infection, or who are under investigation (testing pending), should stay home and the facility should contact their local public health department for guidance. Inpatient and residential facilities must also report to DHCS, within one (1) working day, any events identified in California Code of Regulations Title 9 Chapter 5 Section 10561(b)(1), which would include cases of communicable diseases such as COVID-19.

Q23: What else can behavioral health programs do to prepare for or respond to COVID-19? (Update)

DHCS encourages providers to adhere to the [CDC's](#) and [CDPH's](#) recommendations to prepare for and respond to COVID-19.

Q24: May providers claim for telephone and telehealth services?

Yes, both SMHS and SUD services may be provided via telehealth. Please refer to the following ACBH and DHCS resources:

1. [Leveraging Technology to Meet Client Needs – New Guidance from DHHS-OCR](#) (issued on March 18, 2020)
2. [Leveraging Technology to Meet Client Needs – Non-Licensed Staff Update](#) (issued on March 19, 2020)
3. Specific guidance for providers regarding HIPAA and telehealth is available from the external resources listed on DHCS' [Telehealth Resources](#) page.

Q25: May providers claim for services provided via text messaging to clients during the COVID-19 emergency?

No. We have now received updated guidance from DHCS that there is no claiming for texting clients at this time. Texting is only allowed for scheduling appointments with clients. DHCS Legal is vetting any additional use of texting.

Q26: May providers claim for services provided via email messaging to clients during the COVID-19 emergency?



No. At this time, DHCS has not given permission for claiming for email communication. When a beneficiary consents to the use of email communication, and that consent has been documented, counties may send SMHS and SUD notices via email. Providers must remain HIPAA and 42 CFR Part 2 compliant.

Q27: May a LPHA provider whose license has expired continue to provide services if they are unable to renew their credential with their licensing board at this time?

Yes. for additional information, please see below:

- 1. Order Waiving License Renewal Requirements:
https://www.dca.ca.gov/licensees/continuing_ed.pdf*
- 2. Order Waiving License Reactivation or Restoration Requirements:
https://www.dca.ca.gov/licensees/reinstate_licensure.pdf*

Q28: Will late signatures (Informing Materials Consents, Client Plan and Medication Consents) be accepted as compliant for claiming purposes if verbal consent is provided?

Yes, for those documents listed above—but not for Release of Information forms (ROI). In the session's progress note, explain specifically what information was shared with the client, that the client verbally consented to the information provided, and that due to the COVID-19 emergency the client was unable to meet in-person and sign the document. As well, during this public health crisis ACBH has temporarily suspended the requirement for client signature for receipt of psychiatric medication during this time of emergency (Cal. Code. Regs. tit. 9 § 852).

Q29. May the platform DocuSign be utilized to obtain electronic signatures?

Yes, during the COVID emergency, HIPAA-compliant electronic signature platforms such as DocuSign may be used for both staff and client electronic signatures. However, a Business Associate Agreement must be in place with the electronic signature vendor in order to utilize HIPAA-compliant platforms.

Q30. When the emergency ends, does ACBH expect that providers will go back and obtain treatment or client plan signatures for clients that are still in treatment?

No, Providers are not expected to get signatures from beneficiaries who receive Specialty Mental Health Services and SUD services during the time period of the COVID-19 public health emergency. When the public emergency ends, providers shall resume compliance with all documentation and signature requirements and update all clinical records on a "go-forward" basis.

Q31: Can the client provide verbal consent for a Release of Information (ROI)?

No. The U.S. Department of Health and Human Services has not waived the signature requirements of written authorizations for client releases of information. You may discuss the release of information with the client and mail the forms to them for their signature (it is suggested you enclose a self-addressed stamped return envelope as well). A copy, fax, or photo sent by email or text will be acceptable for a signed ROI. A witness signature is not required on the ROI form.



Q32: (MH only) Under what circumstances could a provider disclose PHI to a family member, relative, close friend, or other person identified by the individual without an ROI?

A provider may disclose PHI to a family member, relative, close friend, or other person identified by the MH (not SUD) client as responsible for their care without an ROI under the following circumstances when the client is NOT present:

- 1. The family member, relative, close friend, or other person has already been identified by the client as responsible for their care;*
- 2. The PHI is used to notify or assist in the notification of (i.e. identifying/locating) this family member/person responsible for the client's care of the client's location, general condition or death;*
- 3. The provider determines in their professional judgment that the disclosure is in the best interest of the client; AND*
- 4. The provider discloses ONLY the PHI directly relevant to the person's involvement with the client's care or payment related to the client's care or for notification (i.e. minimum necessary).*
- 5. For example, the provider may infer that it is in the client's best interest to allow the other person to act on behalf of the client in picking up filled prescriptions, medical supplies, or other similar forms of PHI*
- 6. See 45 CFR 164.510(b)(3). <https://www.law.cornell.edu/cfr/text/45/164.510>*

Q33: If a provider has lost contact with the client during the COVID-19 emergency, may they contact a family member (or another person) without a signed Release of Information in order to locate the client?

*Yes, but **only if they do not disclose any PHI** to the person with whom they are speaking. This includes **NOT** disclosing that the caller works for a behavioral health services provider.*

Q34: Has ACBH issued any additional guidance on Telehealth and HIPAA privacy and security?

Yes, the Alameda County Health Services Agency Office of Compliance Services issued the following guidance:

- 1. Remote Work and HIPAA Privacy and Security: [March 2020 COVID-10 Remote Work and HIPAA Privacy & Security Guidelines for HCSA Staff.](#)*
- 2. Telehealth and HIPAA Privacy and Security: [March 2020 FAQs: COVID-19 Telehealth and HIPAA Privacy & Security](#)*

Q35: Are there any exceptions to obtaining client written consent before disclosing Protected Health Information (PHI)?

- 1. Specialty Mental Health Services (SMHS): Yes, a MH provider may disclose PHI to another HIPAA-covered health care professional (mental and/or physical health) for the purpose of treatment, and for health care operations activities including care coordination (e.g. referrals) for mutual clients*
- 2. Substance Use Disorder Services (SUD): Yes, a SUD provider may disclose PHI without written consent to medical personnel in order to treat a bona fide medical emergency based on the SUD provider's discretion. However, this provision may NOT be used to override a client's objection to disclosure.*

(See SAMHSA Guidance: [COVID 19 Public Health Emergency Response and 42 CFR Part 2 Guidance.](#))



Q36: During the COVID-19 emergency many of our clients desperately need case management services to link them with critical community services. If I am unable to meet with the client in person to obtain a written ROI, how can I advocate on their behalf for services that do not meet the above exceptions?

If you are speaking with the client on the telephone or via telehealth, you may ask their consent to add another service provider to a multiparty conference call. An ROI is not required in this situation because the client is on the original phone call, implying consent.

Q37: When providing Telehealth services, do I use the face-to-face or non-face-to-face codes?

Telehealth services, including for assessments such as CANS and ANSA, will be coded as face-to-face service. Please note, that location code 20 is indicated in the medical record when claiming for telehealth services.

Q38: Are written Telehealth Consents required before Telehealth Services begin?

No, during the emergency period, the requirement for written or verbal consent is suspended for Telehealth Services. The requirement for written consents for Telehealth Services will resume after the emergency ends. (See [Executive Order N-43-20](#).)

Q39: Is there an ACBH required Telehealth Consent form to use?

No. ACBH is in the process of developing a Telehealth Consent Form for future use.

Q40: During the COVID-19 emergency has there been any changes to the NOABD and State Fair Hearing Appeal process?

Yes, from March 1, 2020 through the conclusion of the COVID-19 emergency clients will have 240 days (rather than 120 days) to file for a State Fair Hearing when their Appeal is denied by ACBH. When NOABD's are issued to the client—an additional insert must be added. See: [ACBH Grievance System](#)

Q41: Where can I find COVID testing resources?

<http://www.acphd.org/2019-ncov/testing.aspx>

<http://www.acphd.org/media/571443/alameda-county-covid-testing.pdf>

Q42: (SUD only) Can ACBH clarify that assessment and medical necessity and level of care may also be done by telephone for Drug Medi-Cal Organized Delivery System (DMC-ODS) providers

Yes. In anticipation of CMS' approval of DHCS's 1135 Waiver request, beginning on March 1, 2020 and for the duration of the emergency, the initial assessment of the beneficiary may be performed by telephone by an LPHA with the appropriate scope of practice.

Q43: (SUD only) Can the consultation between an LPHA and counselor that is needed for level of care determinations also be done by Telehealth)?

Yes, the LPHA can review the assessment with the counselor through a face-to-face telehealth discussion when establishing the SUD diagnosis, medical necessity, and level of care assignment.



Q44: (SUD only) Can individual counseling services be provided via telehealth and telephone?

Yes. Individual Counseling may be provided via telehealth by ACBH SUD providers.

Q45: Can group counseling services be conducted via telehealth and telephone? If so, does the 12-client limit remain in place?

Yes. Group Counseling services may be provided for SUD and Specialty Mental Health Services and the 12-client group size limit still applies for SUD.

Q46: How can providers ensure their clients do not run out of medications?

- 1. Medi-Cal allows clients to fill up to 100 days of non-controlled medications. Narcotic treatment programs can receive exemptions to provide take-home medications for clients who are sick or quarantined. See [DHCS COVID-19 FAQ: Narcotic Treatment Programs](#) for more detail. Clients receiving buprenorphine products can currently receive 30-day supplies on Medi-Cal.*
- 2. Utilization limits on quantity, frequency, and duration of medications may be waived by means of an approved Treatment Authorization Request (TAR) if there is a documented medical necessity to do so. See [DHCS pharmacy guidance](#).*

Q47: Can controlled substances be prescribed over the phone?

This is a federal, not state, issue. [SAMHSA released guidance](#) that an initial evaluation by telehealth or telephone is allowed for buprenorphine during the emergency. The [DEA COVID-19 website](#) addresses all other controlled substances, which include sedatives and stimulants, under telemedicine. Practitioners can start a new controlled medication prescription by telephone for a patient who is already under their care by telephone. However, if a patient is new to the provider, controlled medications cannot be provided by telephone (other than buprenorphine). For clients new to the provider, prescribing controlled medications can only be done by live video or telemedicine.

Q48: Does ACBH have specific expectations for documentation of services delivered by telephone or telehealth?

Providers may indicate that telephone and telehealth services were provided in lieu of in-person services due to COVID-19 social distancing practices and continue following current documentation requirements.

Q49: (SUD only) Can DHCS waive the requirement that SUD treatment programs maintain a minimum of 30% licensed staff?

No, pursuant to California Code of Regulations Title 9, Chapter 8, Section 13010, at least 30% of staff providing counseling services in all AOD programs shall be licensed or certified.

Q50: Are facilities able to provide treatment or recovery services outside the facility service location if there are concerns about providing treatment at the location due to COVID-19?

In some circumstances, DHCS shall consider and may allow facilities to provide treatment or recovery services off-site for any concerns related to COVID-19. Providers should contact their Licensing Analyst for questions. See [COVID-19 Response website](#) for information notices for treatment facilities.



Q51: (MH only) Can a licensed mental health professional provide direction to a Therapeutic Foster Care (TFC) parent through telehealth rather than in person?

Yes. Telehealth and telephone may be used by licensed mental health professionals to provide direction to TFC parents during the emergency.

Q52: (SUD only) During the emergency, are DMC-ODS providers still required to discharge beneficiaries if there is a lapse in treatment for more than 30 days?

Yes. DMC-ODS providers are required to discharge beneficiaries when there is a lapse in treatment for more than 30 days, although beneficiaries can be readmitted. Beneficiaries should be reassessed for readmission when ready to resume treatment. Note: the two non-continuous residential stay limit still applies in DMC-ODS (1115 Waiver, Standard Terms and Condition (STC) 138-Residential Treatment).

Q53: (MH only) Is DHCS waiving the 23-hour maximum length of stay in a Crisis Stabilization Unit (CSU) during the emergency?

No. DHCS is not waiving the maximum length of stay requirement in a CSU, specified in California Code of Regulations, Title 9, Section 1810.210. However, in cases where a beneficiary remains in a CSU for more than 23 hours, the provider must be able to present evidence upon request by DHCS of good faith efforts they have made to transition the beneficiary out of the CSU to their residence or to an appropriate placement, including the reason(s) why that has not been possible.

Q54: (MH only) Are psychiatric health facilities (PHF) and CSUs allowed to offer services outside of the licensed part of the facility at locations that are already Medi-Cal certified for outpatient services?

DHCS will review requests regarding PHF licensing on a case-by-case basis (LCDQuestions@dhcs.ca.gov). For Medi-Cal Certification related questions, including those pertaining to CSUs, DHCS will review requests on a case-by-case basis (DMHCertification@dhcs.ca.gov).

Q55: (MH only) DHCS requests proof that there is a psychiatrist and licensed person (LCSW, LMFT) on the PHF unit each day, which is later audited for the hours of attendance. May psychiatrists be available by telehealth, off-site? And can this obligation be addressed by having two licensed staff at a time?

DHCS will review requests regarding PHF licensing requirements on a case-by-case basis (LCDQuestions@dhcs.ca.gov).

Q56: (SUD only) During the emergency, is it possible for DMC-ODS to use non-registered or non-certified staff with lived experience working under the supervision of licensed and/or certified staff to provide services in Recovery Support and Case Management?

The current requirements for providing Recovery Support and Case Management services have not changed during the public health emergency.



Q57: (SUD only) During the emergency, may Alcohol or Other Drug (AOD) counselors provide services after their certification expires, while waiting for the renewal?

As outlined in MHSUDS IN 18-056, if an AOD counselor fails to submit a renewal application prior to the expiration of their certification, the counselor may not provide counseling services until their certification is renewed. But, if an AOD counselor submits a renewal application prior to the expiration of their license, the counselor may continue to provide counseling services unless the certifying organization denies the renewal application. If the counselor's certification is denied, any service provided after the expiration date of the counselor's certification shall not be reimbursed with State or federal funds.

Q58: How do providers access federal grant opportunities?

1. Providers should stay updated by regularly checking the federal websites for grant opportunities. DHCS has a web page that reflects a compilation of websites that may be followed to search for grant funding opportunities. These links can provide more information on the following opportunities: provider relief fund; [Grants.gov](#); [telehealth](#); [small business loans](#); and [SAMHSA grant announcements](#)
2. The Small Business Administration recently issued two interim final rules to supplement previously posted interim final rules on the [Paycheck Protection Program \(PPP\)](#) with additional guidance regarding [disbursements](#), as well as guidance on the [amount of PPP loans that any single corporate group may receive and criteria for non-bank lender participation in the PPP](#).

Q59: Does DHCS provide an outreach letter to Medi-Cal Beneficiaries regarding COVID-19?

Yes, see <https://www.dhcs.ca.gov/Documents/Beneficiary-Outreach-Letter.pdf>
This is an excellent resource to provide to clients during the COVID emergency.

Q60: Are there COVID resources for Spanish speaking individuals?

Yes. MUA Publishes a COVID19 Resource Guide for the Immigrant Community
<https://bit.ly/MUAGuiaCOVID19>

Q61: Are there support resources for staff and providers during the COVID emergency?

Yes. See local staff COVID support resources below.

1. In collaboration with Alameda County Psychological Association (ACPA), Crisis Support Services of Alameda County (CSS) is rolling out the Staying Strong Against COVID19 Support Line for Bay Area Workers in Healthcare Settings. For this resource please call [510-420-3222](tel:510-420-3222).
2. The COVID19 Pro Bono Counseling Project is an organization offering free video and phone therapy to front-line healthcare workers in the Bay Area during the COVID19 crisis. See:
<https://sites.google.com/view/cpbc-proj/home> and
<https://www.youtube.com/watch?v=5rgI5T1Vxgo&feature=youtu.be>