Coronavirus (COVID-19)
Home and Community Support Services Agencies (HCSSAs), Including Hospice
Inpatient Units
Weekly Frequently Asked Questions

On March 13, 2020, Governor Greg Abbott declared a state of disaster for all counties in Texas due to the COVID-19 pandemic.

The Texas Health and Human Services Commission (HHSC) is committed to sharing pertinent COVID-19 information with all HCSSAs via this regularly updated Frequently Asked Questions (FAQs) document.

With each update, this FAQ document will be arranged by date. If guidance changes from a previous week's FAQs, it will be noted in red font with brackets under that earlier date. Questions regarding these FAQs can be directed to Long-term Care Regulatory Policy, Rules & Training at 512-438-3161 or PolicyRulesTraining@hhsc.state.tx.us.

Please note that this FAQ document and other policy guidance by HHSC Long-term Care Regulatory, such as Provider Letters 20-16, 20-17, and 20-21, relates to state licensing standards and requirements governing Home and Community Support Services Agencies (HCSSAs) in 26 Texas Administrative Code (TAC), Chapter 558. HCSSAs that participate in Medicare or contract for Medicaid or other programs must also follow applicable federal regulations, applicable state program rules and contracts, and policy guidance for their contracted programs, including guidance related to reimbursement requirements.

July 16, 2020

<added> Can agency staff use a cloth face covering that has filter inserts?

Answer: The CDC states that cloth face coverings are "textile (cloth) covers that are intended for source control. They are not personal protective equipment (PPE) and it is uncertain whether cloth face coverings protect the wearer." Additionally, the CDC states "*Cloth face coverings are NOT PPE and should not be worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a respirator or facemask is recommended.*" Therefore, a cloth face covering (with or without filter inserts) should not be used per current CDC guidance. <added>

What if a household member refuses to participate in the screening process?

Answer: If a household member declines to be screened, then the agency should educate the household members about the reason for the screening and the efforts to keep the client safe. The agency can also have the staff use an appropriate amount of PPE based on existing risk factors (i.e., the services to be provided, the staff's potential exposure to the household members, other screening criterium that is known to the staff) while providing only essential services. If an agency cannot let staff continue to use limited PPE because of uncooperativeness by a client's household member, the agency can postpone all essential visits or discharge the client in accordance with the applicable rule requirements.

How should we handle a household member who has a fever of an unknown origin, which may not be related to COVID-19?

Answer: If a household member meets one of the enumerated screening criteria, which includes fever, without regard to known or unknown origin, agency staff making an in-person visit to provide an essential service must use all appropriate PPE, considering the risk factors and proximity to the household member. If the symptomatic household member is to remain in a closed and separate room from the client and staff during the visit, then staff could limit PPE to a surgical mask and gloves.

How should we conduct a screening for a client who lives in a care facility? Do we call and get daily screening information from the facility?

Answer: Yes. HHSC recommends an agency call the facility in advance of the visit. Since facilities are required to screen their residents each day, the agency should ask for the facility's screening information for the client conducted that day. The agency should also ask if the facility has any active COVID cases. An agency can talk with facility staff about the outcome of the client's screening ahead of the visit, then document the information provided by the facility. Agency staff should use pertinent screening information in determining the appropriate PPE to use but must also follow all infection control protocols of the licensed facility, as required by emergency rule 26 TAC §558.408(c).

For agencies that have more than 400 clients, are we expected to call all 400 clients every day?

Answer: HHSC does not expect agencies to call all their clients every day. HHSC requires agencies to screen clients and household member *before every home visit*.

Has CMS issued anymore waivers?

Answer: CMS Coronavirus Waivers & Flexibilities lists the documents describing waivers and flexibilities by provider type. Home Health Agencies: CMS Flexibilities to Fight COVID-19 was updated on May 15, 2020. Hospice: CMS Flexibilities to Fight COVID-19 was updated on May 15, 2020.

What do you mean by full PPE?

Answer: Full PPE means gloves, gown, surgical mask, and face shield or goggles. If the client is positive for COVID-19 or suspected positive, then an N95 mask is used instead of a surgical mask.

If a client is in self-quarantine and receiving services, should staff wear full PPE even if the client is asymptomatic?

Answer: Yes. During quarantine for any client, agency staff should wear full PPE for the entire duration of the quarantine, even if the client is asymptomatic.

Is an agency supposed to tell the physician about all missed visits? What if the client cancelled the visit or a facility denied agency staff entry?

Answer: If the physician has been involved in the client's care and the missed visit, regardless of the reason, could impact the client's condition, course of care, or a physician's order or care recommendations, it is important for the agency to communicate that information to the attending physician. This decision is made on a case-by-case basis.

PAS Infection Control Probe Tool question: How often should the tool be used? How much of the infection control checklist information would HHSC expect to be present at the home when inspected? Should the checklist be included in the client's record?

Answer: The PAS Infection Control Probe Tool is an overall review of a PAS agency's infection control policies. It is not a checklist to be used for each client or during every home visit. The tool should be used by PAS agencies to review their infection control practices. Use of the tool is not required but could be an important part of an agency's Quality Assessment and Performance Improvement (QAPI) process. The tool is being provided to PAS agencies because HHSC's survey staff will use it in focused surveys related to infection control.

HHSC encourages a PAS agency to use the tool to promptly and carefully review its infection control policy and procedures, as well as to review and, as needed, update its policies, procedures, and practices to keep it aligned with evolving COVID-19 circumstances and additional guidance as it becomes available. For instance, if return-to-work guidance changes, an agency should ensure its policy reflects the updated guidance.

Where can I find an infection control checklist for home health agencies like the one HHSC has for PAS agencies?

Answer: There is no infection control probe tool specifically for home health

agencies. HHSC recommends home health agencies modify one of the following assessment tools for use in the home health setting:

- CDC's Infection Prevention and Control Assessment Tool for Long-term Care Facilities
- CDC's Infection Prevention and Control Assessment Tool for Outpatient Settings
- CMS QSO 20-20-All memo – Contains survey tools titled "COVID-19 Focused Survey for Nursing Homes" and "COVID-19 Focused Infection Control Survey: Acute and Continuing Care."

The PAS Infection Control Probe Tool asks if the agency provides hand hygiene supplies if needed. Please define "if needed." My agency doesn't normally provide soap and disinfection supplies unless it is needed for a COVID-19 positive client. Do agencies now have to provide soap and disinfectant supplies for every client?

Answer: An agency doesn't have to provide disinfectant supplies to every client. However, while an agency staff person is providing services, and if the client doesn't have hand hygiene supplies available for the staff, the agency must supply appropriate hand hygiene supplies to its staff, regardless of whether a client is known or suspected to be COVID-19 positive. This ensures staff can practice appropriate infection control procedures while at the client's home.

Is an agency expected to provide all types of PPE, including gowns and cleaning supplies, to its staff even when staff are not working with clients who have COVID-19?

Answer: An agency must determine which PPE is necessary based on the task to be performed and the results of the screening of the client and household members. If a gown is indicated, then a gown should be provided by the agency and worn by the staff. Regarding cleaning supplies, cleaning the area before and after performing a task is also an important component of infection control. If the client doesn't have appropriate routine cleaning supplies for staff to use, staff should communicate that to the agency. An agency must provide cleaning and disinfection supplies for staff providing care and services for the client. However, an agency is not obligated to purchase routine cleaning supplies for a client, even if the required task is cleaning the client's home.

Should agencies email HHSC Long-term Care Regulation if staff are denied access to a facility?

Answer: Yes. HCSSAs are encouraged to send an email to PolicyRulesTraining@HHSC.state.tx.us that includes a description of the situation, the name and location of the facility, the name and location of the HCSSA, and the name and phone number of a contact person for the HCSSA.

Why does a HCSSA have to dispose of a PPE gown after exiting a home? Why can't that gown be used again for that client only?

Answer: Since gowns are worn for positive cases of COVID-19, as well as

suspected cases, the reuse of a gown for the same client increases the risk to the staff person who must handle the gown multiple times. The risk of infection for the staff person also increases the risk for other clients the staff visits because the staff might become an asymptomatic carrier of the virus.

Does HHSC have any guidance to help a client who lives alone and has to self-quarantine?

Answer: A HCSSA remains responsible for providing services, including in-person essential services, to a client during the client's self-quarantine. However, an agency also can make referrals to other entities on the client's behalf. 2-1-1 is an available resource for either a client or the agency to call to inquire about possible wrap-around services for the client. This might include services to get supplies to a client or to make sure the client is safe between agency visits. Contacting Adult Protective Services also would be appropriate if there is reason to believe that living alone might put the client's safety at risk.

What should a PAS agency do if a client tests positive for COVID-19, is blind, lives alone, and has no informal support?

Answer: HHSC would expect the agency to assist the client in seeking residential services outside the home to ensure the client's safety. A discussion with the client's attending physician would be appropriate. The local health department and 2-1-1 also might be able to provide supports.

What is an essential visit?

Answer: An essential visit is one that includes a service that must be delivered to ensure the client's health and safety, such as medication administration or wound care. This determination is made on a case-by-case basis and according to the client's need for the service *on the day of the scheduled visit*. For example, if the service is a bath, and the client had a bath two days before, the agency might determine that a bath that day is not essential. But if the client's last bath was five days before, then the agency could determine that a bath that day is essential.

Is performing an assessment an essential visit, or could that be done by some other means?

Answer: If an assessment is not required where the services are to be delivered and can be adequately performed via telecommunications, HHSC encourages an agency to use authorized telecommunications to perform the assessment.

To maintain social distancing, can a HCSSA conduct staff education by phone, text, or mailing out education materials?

Answer: Required training and education must be conducted in a mode and manner that effectively meets all rule requirements. Within those parameters, HHSC encourages HCSSAs to provide staff education and training through whatever means works best for the agency's business to satisfy applicable requirements.

If a HCSSA staff person has a family member who has COVID-19-like symptoms or is suspected of having COVID-19, but the staff person is asymptomatic, can staff continue to provide services?

Answer: Emergency rule 26 TAC §558.408(d) prohibits a HCSSA from allowing staff to remain in the agency or make a home visit if the person has had contact within the previous 14 days with someone who has a confirmed diagnosis of COVID-19, someone who is under investigation for COVID-19, or someone who is ill with a respiratory illness.

I recently heard that a HCSSA must accept a client with COVID-19 to take pressure off the hospitals. If this is true, what are the consequences of not accepting a client with COVID-19?

Answer: HHSC licensing rules do not require a HCSSA to admit a client with COVID-19. However, an agency might be required to admit an individual based on the agency's contract with payor source (such as Medicaid). An agency should communicate with the payor source's contract manager to determine the consequences of refusing to admit an individual with COVID-19.

Do clients need to wear masks if they are not COVID-19 positive or symptomatic? Clinicians are wearing masks on all visits, but do the clients also need to wear masks?

Answer: HHSC strongly recommends that clients and household members wear masks or cloth face coverings.

Does a durable medical equipment technician have to screen a client and household members before a visit?

Answer: Yes, and also use appropriate PPE based on the screening results.

Our HCSSA received only a portion of the PPE it ordered through a State of Texas Assistance Request (STAR). Can we re-request PPE from STAR?

Answer: Yes, an agency should re-request PPE. The State of Texas Assistance Request (STAR) User Guide provides instructions for submitting a request.

If a PAS agency attendant lives with the client, does the attendant need to use PPE when providing services to the client?

Answer: A staff would not need to use PPE when providing services to a client with whom the staff lives.

Does an agency have to provide full PPE (N95 mask, gloves, gown, face shield/goggles) to staff regardless of whether the client has COVID-19?

Answer: If a client has COVID-19 or is suspected of having COVID-19, the HCSSA should provide staff with *full* PPE to wear, including an N95 mask, when providing essential services. Otherwise, the agency must determine which PPE is appropriate for the staff to use depending on the risk factors, such as how many screening criteria the client has met and the nature of the services being provided.

After a client tests positive and has been quarantined for 14 days, must the client be retested before client services are resumed?

Answer: HCSSAs are expected to continue to provide client services according to rule and HCSSA emergency rule 26 TAC §558.408, even if a client tests positive for COVID-19. This includes providing in-person essential services in the home with full and appropriate PPE, including a fit-tested N95 mask for a client who has tested positive for COVID-19 for at least 14 days, as well as long as the client exhibits symptoms.

How can a HCSSA determine if a particular disinfectant product will actually kill the COVID-19 virus?

Answer: List N on the Environmental Protection Agency's website contains disinfectants for use against SARS-CoV-2. An agency can search the list by entering the product's EPA registration number, which is found on the product's label.

Does HHSC have any guidance on the use of UV-C lights for disinfecting purposes?

Answer: HHSC recommends following CDC guidance for Cleaning and Disinfecting Your Facility. That guidance recommends the use of only List N surface disinfectants, and it states, with respect to alternative disinfection methods, such as UV-C lights:

> The efficacy of alternative disinfection methods, such as ultrasonic waves, high intensity UV radiation, and LED blue light against COVID-19 virus is not known. EPA does not routinely review the safety or efficacy of pesticidal devices, such as UV lights, LED lights, or ultrasonic devices. Therefore, EPA cannot confirm whether, or under what circumstances, such products might be effective against the spread of COVID-19. CDC only recommends use of the surface disinfectants identified on List N against the virus that causes COVID-19.

The following three FAQs are specific to hospice:

Are hospices mandated to test their patients and staff for COVID-19 regardless of the setting?

Answer: No. Hospices are not addressed in the governor's directives for statewide testing of nursing facility staff and residents. However, a hospice patient who is a nursing facility resident is subject to the same testing administered to other nursing facility residents. Inpatient hospice units should conduct daily screenings of all patients. Hospice staff conducting a home visit are required to conduct the same screening of clients and household members that other HCSSA staff are required to conduct. Hospice staff (home visit staff and inpatient staff) should use appropriate PPE based on the situation and maintain hygiene while attending to the patient/client.

What if a hospice staff member has COVID-19? Must the hospice test the hospice patient(s)?

Answer: Testing of a hospice patient who has been exposed to a hospice staff member who is positive for COVID-19 will depend on several factors: the local health department's direction, the condition of the hospice patient/client, and the direction of the attending physician for the patient/client. A hospice should also refer to how its own infection control policies address the situation in deciding how the determination is made.

How many family members can be in the room with someone who is actively dying? Does the hospice or the facility make this policy? What about local ordinances?

Answer: An end-of-life situation does not negate required infection control practices, and emergency rule 26 TAC §558.408(c) requires hospice staff to follow the infection control protocols of a licensed facility. However, considerations would include, at a minimum:

- The capacity for social distancing in the space;
- Risks for the family members (age, medical conditions, whether they live together, etc.);
- Availability of PPE (masks, gloves);
- The extent of infection control education provided to the staff and family members/visitors;
- Compliance with infection control precautions by family members/visitors; and
- The adequacy of facility and hospice infection control policies, procedures, and practices.

The following FAQs are specific to inpatient hospice units:

They are from the Hospice Inpatient FAQ document on the HHS Hospice home page and are dated April 13-17, 2020.

Can social worker and chaplain reports be conducted via chat/audio/video using the in-patient hospice nurse or the long-term care nurse working for the facility?

Answer: Yes. These services can be provided via telecommunications.

Should an in-patient hospice use telehealth only if the patient has answered yes to one of the screening questions?

Answer: Any visit that can be conducted via telehealth should be in the important effort to prevent the spread of COVID-19.

Are vendors that inspect, test, and maintain fire systems considered essential and be granted entry into an in-patient hospice facility?

Answer: Yes. These are considered essential services, and these vendors should be granted access to the facility – but only if they are screened and follow the appropriate CDC guidelines for transmission-based precautions. See CMS QSO-20-

14-NH and CDC guidance for Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID- 19.

How do in-patient hospice providers report confirmed cases of COVID-19?

Answer: <added>In-patient hospices must report confirmed cases to their local health entity or the regional office for the Department of State Health Services (DSHS) if there is no local health entity or the local health entity will not accept the report. See the listing of local health entities by county at Coronavirus Disease 2019 (COVID-19) Local Health Entities. See Public Health Regions for a listing of DSHS Regional Offices. <deleted>~~In-patient hospices must report confirmed cases to their local health department or the Department of State Health Services (DSHS) if there is no local health department.~~ <deleted> Home and community support services agencies, including in- patient hospices, are exempt from critical incident reporting of cases of confirmed COVID-19 to HHSC.

When should masks be worn in an in-patient hospice facility?

Answer: Anyone with a confirmed or possible case of COVID-19 should wear a facemask if in the same room with another person. Healthcare personnel or other caregivers should wear an N95 respirator mask (or facemasks, if respirators are not available) when caring for patients with COVID-19.

What should I do if my supply of facemasks is running low?

Answer: Restrict the use of facemasks to caregivers and to symptomatic persons. (If necessary, restrict to healthcare personnel and other caregivers only). See additional CDC guidelines: Strategies for Optimizing the Use of Facemasks.

How do in-patient hospice facilities get personal protective equipment (PPE)?

Answer: Providers must have personal protective equipment available. You should try to get PPE through your normal supply chain or through other resources available to you first. Some resources are sister facilities, local partners or stakeholders, the Public Health Region, Healthcare Coalition, or Regional Advisory Councils.

If you can't get PPE from vendor(s) and have exhausted all other options, reference the State of Texas Assistance Request (STAR) User Guide for instructions on submitting a request for supplies. Please note that this is not a guarantee of receiving PPE, as supplied might be insufficient to meet demand.

Providers who are having difficulty getting PPE also should follow national guidelines for optimizing their current supply or identify the next best option to care for people receiving services from the provider while protecting staff. If providers are unable to get PPE for reasons outside their control, they should document their attempts to obtain PPE and provide to HHSC surveyors if requested.

Other helpful resources include:

- Public Health Region https://www.dshs.state.tx.us/regions/default.shtm

- Local Public Health Organizations https://www.dshs.state.tx.us/regions/lhds.shtm
- Texas Division of Emergency Management: https://tdem.texas.gov/
- The 22 Regional Advisory Council (RACs) in Texas, each of which is tasked with developing, implementing, and monitoring a regional emergency medical service trauma system plan. Providers also can contact their RAC to request PPE.

Is family allowed to visit in-patient hospice patients?

Answer: Family members and loved ones of patients at the end of life are permitted to visit them in an in-patient hospice facility as long as they do not meet any of the screening criteria for COVID-19. This exception does not apply to all patients in an in-patient hospice, but only to those whose death is imminent.

Facilities should decide on a case-by-case basis when a patient's death is imminent and follow CMS and CDC guidance for visitation, including appropriate isolation practices. See CMS QSO-20-14-NH and CDC guidance for Preparing for COVID-19 in Nursing Homes. Provider letter 20-17 provided guidance for providers that explains screening criteria, infection control and prohibition of visitors, along with links to resources such as HHSC, DSHS, and the CDC.

Is there a checklist for COVID-19 for long-term care facilities that might be helpful to inpatient hospices?

Answer: Yes. The CDC has issued updated guidance for preventing the spread of COVID-19 in long-term care facilities, which includes a preparedness checklist: CDC: Preparing for COVID-19 in Nursing Homes .

If a patient with confirmed or suspected COVID-19 is being transferred to an in-patient hospice facility from another health care facility, does the transferring facility have to inform the in-patient hospice facility?

Answer: Yes, the transferring facility must inform the in-patient hospice facility that the patient is suspected or known to have COVID-19. The hospice facility should explicitly confirm with the transferring facility whether the patient is suspected or known to have COVID-19 and take all appropriate precautions.

Where do program providers go for COVID-19 information?

Answer: Reliable sources of information include:

- The Centers for Disease Control and Prevention
- The Texas Department of State Health Services
- The Texas Health and Human Services Commission

This concludes the FAQs that are specific to inpatient hospice units.

Resource: The Occupational Safety and Health Administration Respiratory Protection eTool provides N95 respirator and fit-testing information and resources.

Can orientation for unlicensed staff be conducted via telephone?

Answer: This is permissible, but the agency must determine whether the orientation is appropriate to be conducted by telephone or whether video communication is needed, so that demonstration of an assigned task can be seen.

An agency will need to document that the call/communication took place (date, time, length of call) and what was covered during the call. This information needs to be in the HCSSA's staffing records to show what was done, what was discussed, and what orientation was provided according to the tasks that the staff would perform.

Can an agency conduct initial visits via telehealth and telemedicine?

Answer: Yes, but an agency must determine whether the use of telehealth or telemedicine for the initial visit would be appropriate on a case-by-cases basis, according to the client's needs and circumstances and the agency's policies and procedures. See below for a response that addresses hospice start of care more specifically.

Can a hospice agency use telehealth and telecommunication to perform start-of-care on new hospice patients?

Answer: From a licensing standpoint, HHSC would allow the use of telehealth and telecommunication to start care so a new hospice client can receive services as quickly as possible, as long as an in-person initial assessment is not essential.

Whether the use of telehealth or telecommunication to start care for a new client would be appropriate would depend on the client's needs. For example, even if a prospective client has a legally authorized representative who can provide informed consent, an in-person visit might nonetheless be called for if a client's age or condition would prevent meaningful client participation or impede a client's understanding of information provided at admission.

The prospective client also might have recently left a hospital, so starting hospice for an individual in a significantly deteriorated physical condition might require in-person assessment and interaction.

These and other relevant factors would be important for an agency to consider. The criteria established by emergency rule 26 TAC §558.408 would then guide subsequent visits as well.

Can telehealth be done by a licensed vocational nurse, or does it require a registered nurse?

Answer: The Texas Board of Nursing regulates nursing licensure, standards of conduct, and scope of practice. Board of Nursing rules are in Title 22, Texas Administrative Code, Part 11, and the Board of Nursing website has a web page specific to licensed vocational nurse (LVN) practice that addresses a variety of

scope of practice issues, including LVN's performing telephonic nursing. It also has a page with topic-based contact information. S&CC 07-08 provides additional information specific to HCSSAs.

Does telehealth require an order?

Answer: A health professional providing health services by telehealth is subject to the standard of care that would apply to providing the same health care service or procedure in an in-person setting. If a physician's order is required for the service, it is required regardless of whether the service is in person or delivered by telehealth. In addition, delivery of services by telehealth might require additional orders or specification of parameters within an order to account for the method of providing the service (i.e., via telecommunications).

Can an agency use cloth masks when standard personal protective equipment is not available?

Answer: An agency should be using commercially-produced personal protective equipment (PPE) for staff even when no confirmed or suspected COVID-19 is present, based on the risks associated with the service provided and the risk to the client. <deleted>~~If no PPE is available, a cloth face covering is better for source control than no face covering.~~<deleted> The client can be using cloth or homemade masks based on the availability of PPE and the condition of the client and others in the home environment. The following link provides CDC guidance for optimizing PPE and equipment: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe- strategy/index.html

Can staff and clients wear cloth masks for routine home care in situations with no suspicion of COVID-19?

Answer: <added>A client may wear a cloth mask, but staff must wear commercially-produced personal protective equipment (PPE) for staff even when no confirmed or suspected COVID-19 is present.<added> <deleted>~~Yes, but only if nothing else is available. HHSC also encourages the use of face shields and eye protection in such a situation. See the response to the previous FAQ.~~<deleted>

Many providers have tried to report their COVID-19 patients to their local health departments without success. The local health departments are refusing to take their information. Are they aware that is part of our requirement? Why are they refusing to accept the information? Agencies are documenting their attempts to report but wanted to know if there is anything else HHSC would recommend?

Answer: Each local health entity should have a specific unit or phone number for reporting notifiable diseases. Each local health entity should have an epidemiologist who is doing surveillance for COVID-19 who should take your calls.
If this is not successful, a required report should be made to <deleted>~~DSHS by email at coronavirus@dshs.state.tx.us.~~<deleted> <added>DSHS regional office. See the listing of local health entities by county at Coronavirus Disease 2019 (COVID-19) Local Health Entities. See Public Health Regions for the

listing of DSHS Regional Offices.<added>

What should we do if the agency is unsuccessful in maintaining or hiring staff to provide care to a COVID-positive client?

Answer: First, consult and follow the standard backup services policy required of every agency under 26 TAC §558.290, as well as additional backup planning developed as part of the required emergency preparedness and response plan, which includes a continuity of operations plan. Under §558.290, backup services can be provided by an agency employee, a contractor, or, if the requirements of that section are otherwise met, the client's designee who is willing and able to provide the necessary services. An agency can also make other arrangements that are consistent with applicable HCSSA licensing requirements and exemptions under Health and Safety Code §142.002 and §142.003.

If the client's health, safety, or medical needs warrant it, or pursuant to physician orders, the discharge or transfer of the client might be necessary, though notice must be made to any client physician involved in the agency's care. If an agency still has staffing shortages after following these measures, the agency should document the staffing deficiency and its attempts to follow these policies and plans, including appropriate client transfers and discharges, and make sure the attending physician is aware of the situation.

Does HHSC have any guidance for PAS agencies with respect to their unlicensed staff wearing full PPE when they are not medically trained to don and doff PPE appropriately?

Answer: If unlicensed staff at a PAS agency need to use full PPE, the PAS agency must ensure staff are trained in how to put on and take off PPE properly. The CDC has information about how to put on and take off PPE to minimize infection transmission (see https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html). Also consult and follow provisions for this type of training in the HCSSA's infection control policies.

Below are several other helpful "mini webinars" from the CDC:

- Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig
- Clean Hands - https://youtu.be/xmYMUly7qiE
- Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA
- Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw

Some assisted living facilities and intermediate care facilities for individuals with an intellectual disability or related conditions are requiring HCSSA staff to wear full PPE to provide essential services, even though the facility's own staff are only wearing a mask. Are there any HHSC guidelines requiring this when there are no active COVID-19 cases?

Answer: HHSC expects staff in these facilities to wear masks and use other PPE as appropriate to the care and services being delivered. HHSC does not prescribe the details of facility policies and procedures that are developed consistent with

applicable guidelines and requirements. Within these parameters, agencies and facilities can collaborate about how best to address their respective needs, responsibilities, and expectations so that both can effectively serve and protect all of their clients.

Please note that 26 TAC §558.408(c), Emergency Rule for HCSSA Response to COVID-19, requires agency staff entering a licensed facility to follow the infection control protocols of that facility.

Are clients allowed to transfer to another agency during the COVID-19 epidemic?

Answer: Yes. A client can request transfer or discharge at any time. However, services might not always be available from another agency or service provider.

Return to work question: If an employee reports symptoms of COVID-19, but is never tested for the virus, what is the criteria for return to work?

Answer: <added>The CDC has provided guidance for Return to Work Criteria for HCP with Suspected or Confirmed COVID-19. This guidance includes staff who experienced COVID-19 symptoms as well as those who were asymptomatic. Also, the CDC has provided guidance for Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. This guidance addresses situations in which staff are potentially exposed to someone with COVID-19. <added>

<deleted>~~DSHS has developed return-to-work criteria. Refer to DSHS Strategies for Healthcare Personnel with Confirmed COVID-19 to Return to Work from Home Isolation.~~<deleted>

After exposure, then self-quarantine, does an employee need a medical release to return to work?

Answer: The agency's own policy would govern requirements for a medical release.

Can we use electronic signatures, or just not get signatures for initial visits and assessments?

Answer: For any documentation requiring a signature, an electronic signature is acceptable as long as it contains adequate security and authentication measures to reliably identify the signer and securely transmit the signature. For documentation relating to an initial visit and assessment that does *not* require signature, documentation of required components and indication of the client's understanding is sufficient.

Are telehealth visits approved only for suspected or confirmed positive COVID-19 clients who don't need an essential service, or are they now being encouraged for all clients?

Answer: Telehealth and telecommunication visits can be used for any client, as appropriate to the visit being conducted and services being provided.

Are recordings of the weekly HCSSA webinars on the HHSC website?

Answer: Yes, recorded webinars are available on the HHSC website on the HCSSA home page.

Should home health agency staff be restricted from accessing patients in assisted and independent living facilities?

Answer: CMS does not regulate these facilities. HHSC regulates assisted living facilities (ALFs), but it does not regulate independent living facilities. Home health agencies (HHAs) should coordinate with assisted living and independent living facilities to ensure care is provided in an appropriate and safe manner for HHA clients who are residents of such facilities.

HHAs provide essential health-care services in a variety of community-based settings, including assisted and independent living facilities, and residents of an ALF have a statutory right to contract with an HHA. Moreover, if HHA staff are appropriately wearing PPE and do not meet criteria for prohibiting their access to their clients in the facility, then allowing a resident to receive visits from HHA staff providing critical assistance is consistent with an ALF resident's rights.

See 26 TAC §553.45, Emergency Rule for Assisted Living Facility Response to COVID-19 and 26 TAC §558.408, Emergency Rule for HCSSA Response to COVID-19. Under these emergency rules, agencies can collaborate with facilities about how best to address their respective provider needs, responsibilities, and expectations so that both are able to effectively serve and protect their clients. For information about reporting a facility that refuses access to HCSSA staff to provide essential services, please see FAQs earlier in this document under the date of June 26, 2020.

If a client's physical condition requires staff to be very close to provide services (transfer, feed, bathe), what mask does the client and the staff need to wear?

Answer: If a client has COVID-19, an agency should ensure staff use an N95 respirator, with proper fit-testing. Also, an agency should ensure, for any client, that staff use an N95 respirator for all procedures and activities where there is potential for the client to aerosolize the virus. Otherwise, a surgical mask is appropriate. The client should wear a face mask or cloth mask that fits appropriately.

If the client is medically compromised and readily subject to illness, must an agency provide to the client a similar mask as the attendant is wearing?

Answer: An agency's policies govern this issue.

Should HCSSA staff be using PPE for client personal care (personal hygiene, showers, cooking), if the client doesn't have COVID-19 symptoms?

Answer: An agency should supply and train staff to use PPE appropriate to the

situation and services being delivered. If staff is providing only tasks where social distancing can be maintained (e.g., cooking, cleaning), they can wear less PPE, such as only gloves, or even none – as long as effective, frequent hand-washing and sanitation are observed.

However, consistent with Governor Abbott's Executive Order GA-21, staff are *encouraged to wear face coverings* to reduce the asymptomatic spread of COVID-19, even outside the social distancing area.

Is an agency required to provide a mask to a staff person providing personal care services to a client without COVID-19 symptoms or diagnosis?

Answer: Agency must provide all necessary PPE for attendants to do their jobs safely.

Does an agency whose office staff are not teleworking need to supply its office staff with masks?

Answer: Yes, if the office staff will be accepting visitors and having face-to-face contact with clients in the office. Some localities require masks for all individuals when outside their home.

Do audit surveys focused on infection control apply to PAS agencies?

Answer: Yes, in accordance with 26 TAC §558.285, all agencies must adopt and enforce infection control policies. Since a personal assistance services (PAS) agency does not provide clinical services, their policies will differ from those of a home health or hospice agency. HHSC has developed an Infection Control Probe Tool for PAS agencies to review the effectiveness of their infection control policies. Long Term Care Regulation survey staff will use these prompts to conduct infection control focused surveys. HHSC encourages all PAS agencies to use the tool to determine whether their infection control policies and procedures prevent and control the spread of communicable diseases such as COVID-19.

<deleted>~~Are PAS agencies responsible for ensuring their staff have thermometers?~~

~~Answer: Yes. A PAS agency must ensure its staff have a working thermometer.~~ <deleted>

If someone in the client's household tests positive for COVID-19 and the doctor has recommended that everyone in the household *and the HCSSA's staff serving the client* be on 14-day self-quarantine, is the agency required to send other staff to provide service to the client?

Answer: The agency should evaluate whether in-person services within the 14-day quarantine timeframe are essential. If they are, assign another staff member to provide the services using appropriate PPE.

How long are we allowed to do telecommunication in place of in-person visits?

Answer: That is unknown as this time. HHSC will keep HCSSAs informed of waivers and exceptions through required rule-related notifications in the *Texas Register,* GovDelivery announcements, provider letters, and HCSSA home page postings.

April 23, 2020

How do I get in touch with the Department of State Health Services (DSHS)?

Answer: The following are ways to access DSHS information and staff:

DSHS website: http://dshs.texas.gov/coronavirus

DSHS Contact Information: If you have any questions or would like more information about COVID-19, contact DSHS by email or by phone 24/7:

Email: <added> coronarvirus@DSHS.texas.gov <added>

<deleted>~~coronavirus@dshs.texas.gov~~ <deleted>

Phone: Dial 2-1-1, then choose Option 6. If you experience difficulty when dialing 2-1-1, please email at address above.

For assistance from local health entities, see the listing of local health entities by county at Coronavirus Disease 2019 (COVID-19) Local Health Entities. <added> See Public Health Regions for the listing of DSHS Regional Offices. <added>

Did DSHS update its guidance for public home health service providers?

Answer: Yes, it was updated on <added>May 7, 2020<added>. On the DSHS Coronavirus/ Hospitals & Healthcare Professionals webpage, there is a link for the updated home health service providers at DSHS COVID-19 Guidance for Public Health Home Service Providers (PDF, V.3.0, updated 5/7/2020) under "Infection Control".

Can a HCSSA see a client whose physician is licensed in a bordering state, or does the physician have to be licensed in Texas?

Answer: A HCSSA can see a client whose physician is licensed in a bordering state. The definition for physician in 26 TAC §558.2(92) includes a physician licensed in Texas, Arkansas, Louisiana, New Mexico, or Oklahoma, as well as those commissioned or contracted and serving in the United States uniformed services or Public Health Service.

Should an agency report to HHSC if an agency staff or agency client tests positive for COVID -19?

Answer: No. However, an agency should report a COVID-19 positive case to the local health department *in the* county *of residence or location for the client*. If there is not a local health department, the report should be made to DSHS <added> regional office <added>. (See above for DSHS contact information.)

How does an agency with multiple branch offices in a large service area report cases of COVID? Can our corporate office just report all cases to DSHS?

Answer: When reporting confirmed COVID-19 cases to the local health department, it is important to *report in the county of residence or location for the client* or individual. This enables accurate epidemiological data for hot spots, needed resources, case counts, etc.

Is a HCSSA required to report confirmed cases to both local health department and to DSHS offices?

Answer: You do not need to, nor should you, report a confirmed case to both the local health department and DSHS offices. You are advised to report to the local health entity, and if there is not a local health authority, to report to DSHS <added> regional office. See the listing of local health entities by county at Coronavirus Disease 2019 (COVID-19) Local Health Entities. See Public Health Regions for the listing of DSHS Regional Offices <added>. <deleted>~~Here again is the list of local health entities and public health offices for your convenience. https://dshs.texas.gov/regions/2019-nCoV-Local-Health-Entities/~~<deleted>

How should an agency deal with clients with suspected COVID-19 cases in their homes as far as post mortem care?

Answer: Please see the CDC Collection and Submission of Postmortem Specimens from Deceased Persons with Known or Suspected COVID-19, updated April 30, 2020 (Interim Guidance). This guidance includes information for loved ones who have questions about funerals, touching their loved one after the person is deceased, transportation, etc.

Can an agency accept a client who has tested positive for COVID-19 or is suspected of having COVID-19?

Answer: Yes. HCSSAs are a great line of defense for keeping people out of the hospital system. As with any new client who has a communicable disease or infection, an agency should follow its own protocols, CDC, and DSHS protocols, when accepting and providing care to that client.

Is there a specific teaching form recommended or can our agency use one we have developed?

Answer: HHSC does not have specific client education documents. An agency's governing body or administrator should develop procedures with the best guidance available from the CDC, local, state and federal health departments, and relevant regulations.

An agency should dispel myths related to such things as handmade sanitizers (they are not effective or recommended by the CDC), fever point, social distancing, keeping themselves safe, and agency empowerment. For example, agencies can refuse visits by families, neighbors, and agency staff. Agency staff can also provide accurate information about testing in the area, the need to stay in isolation or

quarantine as appropriate, and the conditions under which a person might need to be hospitalized.

Some family members and caregivers are asking about facemasks and respirators and other PPE. Does an agency have a responsibility to provide PPE to family members assisting the client considering limited PPE resources?

Answer: An agency's first priority is safely providing services to as many of its clients as possible, and that means ensuring staff have access to PPE. Information about facemasks and respirators is available at COVID-19: Facemasks & Respirators Questions & Answers and can be shared with family members and caregivers.

Our agency is having difficulty meeting our frequency of visits as outlined in the plan of care, care plan, or individual service plan. How should we handle this?

Answer: If you are unable to meet the frequency of visits outlined in the plan, update the plan and then document why you are unable to meet its requirements at this time. Be sure to let your client/family/caregiver know of the change and why.

CMS's QSO 20-20-All memo mentioned a self-assessment infection control checklist. Where can I find this checklist?

Answer: CDC's infection control assessment tools can be used for all agency categories to the extent applicable to its services and clientele. The CDC developed these tools to assist health departments in assessing infection prevention practices and to guide quality improvement activities (e.g., by addressing identified gaps). The tools also can be used by to conduct internal quality improvement audits.

When can a provider staff return to work after being diagnosed with COVID-19?

Answer: <added> The CDC has provided guidance for Return to Work Criteria for HCP with Suspected or Confirmed COVID-19. This guidance includes staff who experienced COVID-19 symptoms as well as those who were asymptomatic. Also, the CDC has provided guidance for Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. This guidance addresses situations in which staff are potentially exposed to someone with COVID-19. <added>

<deleted>~~DSHS has developed return-to-work criteria. Refer to DSHS Strategies for Healthcare Personnel with Confirmed COVID-19 to Return to Work from Home Isolation.~~<deleted>

What are CMS's emergency declaration blanket waivers related to OASIS?

Answer: TX OASIS coordinators are providing CMS information to help home health agencies access information due to the COVID-19 public health emergency affecting how providers meet the CMS OASIS Conditions of Participation.

Register here for CMS News Updates to stay current on information that might affect a certified home health agency.

CMS also is providing relief to home health agencies on the timeframes related to OASIS transmission through the following actions:

- Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
- Waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the public health emergency.

Read the emergency waivers released by CMS related to COVID-19. For full details on certified home health agencies and how the waivers affect OASIS, Initial Assessments, and home health agency supervision, please review the List of Blanket Waivers (PDF).

On April 7, 2020, CMS posted a letter to clinicians. The PDF summarizes actions CMS has taken to ensure clinicians have the most flexibility to reduce unnecessary barriers to providing patient care during the unprecedented outbreak of COVID-19.

Contact the Texas OASIS help desk at 833-769-1945 regarding OASIS and iQIES OASIS related issues.

The following FAQs are specific to hospice operations:

If a hospice agency is doing virtual interdisciplinary team (IDT) meetings, can they get the required signatures of attendees at a later time or write down the attendees' names and write a note that these were the people present?

Answer: Signatures are still required; however, an agency can use electronic signature, if available, or can obtain signatures at a later date. The agency should document its efforts to obtain signatures.

If a hospice client wants to be screened for COVID-19, is this considered aggressive treatment? Do we have to discharge the client?

Answer: There is not CMS guidance at this time, but from a licensing standpoint, if testing is available then an agency is not required to discharge because this is a public health measure. The process is determined by your local health authority and the physician.

As a hospice agency, we anticipate needing to pull staff from our alternate delivery site (ADS) to work at our main site because of staffing issues. Can we temporarily alter or halt hours at our ADS?

Answer: Yes, a hospice agency can temporarily close its ADS during this pandemic in accordance with the agency's policies. The agency must:

- forward its office phone to the main site or to a teleworking staff during office hours; and
- post a notice on the front door of the ADS stating:
  - that the site is temporarily closed; and

- the phone number to call during site hours.

The agency does not need to notify HHSC of the temporary ADS closure.

What if a certified hospice is unable to meet the requirements related to volunteers?

Answer: CMS is waiving the requirement at 42 CFR §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and potential quarantine.

How else can hospices help beyond taking care of their own patients?

Answer: Hospices can reach out to their fellow hospices to see if there is a need or a hospice could offer to share its volunteers.

Hospice agencies are still having trouble seeing clients in a nursing facility (NF) or an assisted living facility (ALF). What can we do?

Answer: First, ensure that you are coordinating care with the facility and that you are talking about your role as an essential health care provider for the specific hospice patient. Show the facility the applicable provider letter (PL20-11 for NF, PL20-23 for ALF) that authorizes you as an essential provider can enter the facility. Hospice agencies should have conversations with the IDT to determine strategies for accessing and treating patients in facilities. Agencies should discuss the need for amended agreements or contracts with facilities for back up services.

What about the requirement for a hospice agency to have an RN visit with a hospice client every 2 weeks? Does the visit have to be face-to-face?

Answer: From a licensing perspective, the hospice agency may conduct the RN visit by phone based on the client's situation. An agency may need to be creative. If a nurse has to visit to provide an essential care service, then the hospice might be able to combine the visits, moving the visit timeframe so that there are fewer visits to the client's home. In a NF, a hospice agency may be able to use the RN at the NF to do assessment tasks while communicating by phone with the hospice RN. The hospice agency could develop policies and procedures that work effectively for the agency and the agency's clients.

Could a hospice agency amend its contract with an NF so that the NF RN would be responsible for meeting the needs of the hospice's clients during an emergency?

Answer: Yes, contracts may be amended, but only:

- as appropriate to the needs of the hospice's clients;
- if the NF is able and willing to take on the responsibility; and
- if the hospice and NF are able to coordinate care.

Can a certified hospice use telehealth?

Answer: CMS waivers allow for telehealth services to be provided to patient's receiving routine home care, if it is feasible and appropriate to do so. It also allows

for the face-to-face encounters for purposes of patient recertification for the hospice benefit. If you have questions about payment, reach out to their fiscal intermediary for guidance. For HIPPA Guidance, go to: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

Do hospices have to provide all core services?

Answer: Yes, but considering the circumstances, you might need to look at this on a case-by-case basis. You can ask what is critical and essential today for the patient. It is possible another staff person seeing the patient on a particular day could meet the client's needs that another professional normally does.

Would it be possible to use a long-term care registered nurse to complete the nurse's 15-day visit?

Answer: Yes, review and update (as necessary) your agreement with the facility to ensure roles are updated and clear.

Is a hospice aide or certified nurse aide (CNA) considered a provider of essential services?

Answer: This is determined on a case-by-case basis depending on what the aide is doing for the hospice client.

Are nursing facilities and hospitals being asked to identify COVID symptoms when making referrals to hospice?

Answer: Yes, hospitals know to do this. And it is not unique in this pandemic. A referral to hospice at any time should identify all signs, symptoms, and issues going on with a potential client. It's important when communicating and coordinating care.

Can a nursing facility insist on a negative COVID-19 test before accepting a hospice client even if the client has been at home, doesn't have symptoms, hasn't been exposed to anyone who tested positive, and doesn't meet the criteria for being tested?

Answer: A nursing facility should not require a COVID-19 test in such a situation, especially since testing should only be done in response to a physician's order.

April 10, 2020

How do HCSSAs get more personal protective equipment (PPE)?

Answer: Providers should first try to get PPE through their normal supply chain or through other available resources. Some resources are sister facilities, local partners or stakeholders, Public Health Region, Healthcare Coalition, or Regional Advisory Councils.

If providers cannot get PPE from vendor(s) and have exhausted all other options, ask your local office of emergency management to request some on your behalf

using the STAR system. Please note that this is not a guarantee of receiving it. Supplies of PPE might be insufficient to meet demand.

For the most current guidance on the use of PPE and how to conserve it, access resources from DSHS and CDC. The CDC COVID-19 website has sections for health care professionals and health care facilities.

The CDC also has specific information relating to:

- Healthcare Supply of PPE
- Strategies to Optimize PPE and Equipment
- Strategies to Optimize Eye Protection
- Strategies to Optimize Isolation Gowns
- Strategies to Optimize Face Masks
- Strategies to Optimize N-95 Respirators
- Crisis Alternate Strategies for N-95 Respirators

Where should HCSSA providers go for COVID-19 information?

Answer: Reliable sources of information include:

- The Centers for Disease Control and Prevention
- The Centers for Medicare and Medicaid Services
- The Texas Department of State Health Services
- The Health and Human Services Commission

To practice social distancing, can a HCSSA temporarily close its office and arrange for its office staff to telework?

Answer: Yes, the HCSSA can temporarily close its office to walk-in traffic during this pandemic in accordance with the agency's policies. The HCSSA must:

- Forward its office phone to a teleworking staff during office hours; and
- Post a notice on the front door of the office stating:
  - that the office is temporarily closed to lessen the spread of COVID-19; and
  - the phone number to call during office hours.

The HCSSA does not need to notify HHSC of the temporary office closure.

Are activities of daily living (ADLs) considered essential services?

Answer: Services on the individual service plan (ISP), such as meal prep, bathing, and dressing, could be considered essential services if the client does not have anyone else to help them with those services. ADLs should be evaluated on a case-by-case basis for each client to determine if the visit is essential for that client's health and safety. If the client has family members sheltering with them, daily meal prep might not be an essential task if the family member is handling meals. Laundry might be postponed if the client can wait or a household member can do the task.

We must take into consideration that we are to implement the governor's order to limit contact with others. If a visit can be rescheduled or done by virtual format, the agency should do that. Agency staff should speak with the client and family members about their situation and, using best judgement and weighing the risks, determine what are essential and non-essential services.

Can supervisory visits be conducted by phone or video conferencing?

Answer: Yes. Supervisory visits determined to be non-essential can be conducted via phone or video conferencing.

Regarding the second screening criterion in PL 20-16 that states "contact in the last 14 days with someone who has a confirmed diagnosis of COVID-19, is under investigation for COVID-19, or is ill with respiratory illness" – Don't you mean "*unprotected* contact"?

Answer: Yes, we mean *unprotected* contact. It was *not* the intent of the guidance to prohibit an employee who is providing services while using the appropriate PPE and following infection control procedures from providing services to additional clients while being consistent with the CDC guidelines. If an employee has unprotected exposure in or outside of work, however, the agency must isolate the staff member and monitor the signs and symptoms of the infection consistent with CDC guidelines.

Due to the ever-changing information that we are all receiving, an agency must continue to follow the most current guidance as provided by Health and Human Services Commission (HHSC), the Centers for Disease Control (CDC), the Department of State Health Services (DSHS), and your local public health department to reduce the risk of spreading the virus to individuals served.

Can we discharge a hospice client for cause if the facility in which the resident resides won't let us in?

Answer: Yes. The discharge should be discussed with the client, client's family or legally authorized individual, and the client's attending physician. Prior to discharge, the hospice should communicate with the facility to explain the nature of essential hospice services for the client.

Some staff have badges, and some do not; can they carry a letter on the company letterhead to assist in identification?

Answer: Yes. An agency should have procedures for non-badge holders to identify themselves to facility staff and to law enforcement. A letter on company letterhead would work for this purpose.

Can the hospice social worker and chaplain reports be done via chat/audio/video using the hospice nurse or the long-term care nurse working for the facility?

Answer: Yes. These reports can be done as part of an agency's agreement with the facility.

Do we still have to conduct visits if we need PPE and none is available?

Answer: No. In situations where a client or household member has failed a COVID screening, HCSSA staff are not required to conduct visits without PPE when it is unavailable. Essential visits that are not conducted must be documented along with justification for the visit not occurring. Also, the client's attending physician must be notified of the missed visit.

Does screening of the client and household members need to be documented every time it occurs?

Answer: Yes, screening and its documentation is always necessary.

Do our aides need to wear PPE regardless of presence of any infection or signs and symptoms?

Answer: PPE should be used only if the client or a household member meets any of the screening criteria, unless use of PPE is appropriate to the service being provided (e.g., wound care). Refer to CDC guidelines for optimization of PPE.

What happens to our clients when unlicensed attendants are under a shelter-in-place order?

Answer: Most local shelter-in-place orders provide exceptions for health care staff. All HCSSA licensed categories provide health care services, and licensed staff and attendants are essential health care personnel. Agencies are encouraged to issue name badges or letters on company letterhead identifying staff as a provider of health care in a client's home.

What should an agency do if attendants refuse shifts? We do not have enough staff due to daycare closures, illness, and exposure risks.

Answer: This is where the agency's emergency preparedness and response plan is essential. Implement the agency's staff back-up plans, such as having arranged for a household member to provide services in an emergency. The household member would have agreed and been trained for an emergency such as a pandemic. Ultimately, an agency must document all its efforts to ensure adequate staff and that services are provided to clients. An agency also must communicate with the client's physician related to any missed visits.

What if our clients are asking for a postponement of their visits? Can we do telecommunication visits?

Answer: Yes, non-essential services can be provided via telecommunication visits. The client always has the option to refuse a visit or request postponement. An agency must document a client's refusal or postponement request.

For client screening, is it a positive screening if they meet only one criterion/symptom (such as a cough with no other symptoms), or do they need to meet multiple criteria?

Answer: Yes. Any single criterion that is met results in a positive screening.

Is an agency able to extend the date of a supervisory visit if the client is quarantined due to COVID19?

Answer: Yes, the visit can be extended.

Some parents of CLASS waiver recipients are still requesting specialized therapies. Is a specialized therapy (such as Music Therapy, Recreation Therapy, Aquatic Therapy and Massage Therapy) essential?

Answer: Specialized therapies continue if the client's service planning team determines the therapy is an essential service. The determination and justification for the determination must be documented.

Does our ability to do telehealth instead of face-to-face visits apply only if the client or household member answered yes to one of the screening questions?

Answer: No, HHSC encourages agencies to limit contact as much as possible.

Does an agency have to continue to provide services to a client who is diagnosed with COVID-19?

Answer: If the service is determined to be an *essential* service, yes, the HCSSA must provide it unless a household member is willing and able to provide the service or some of the services. Preventing hospitalization should be the goal, if possible. With the agreement of the client, agency staff can enter the home. However, the agency must adhere to all CDC guidelines for the use of PPE, such as goggles, masks, gloves, and disposable gowns.

The agency must reschedule all *non-essential* services to a time when the client has tested negative for COVID-19, has been fever-free for at least 24 hours *without* the aid of medications to reduce fever, or is symptom- free.

If the client lives with someone who has tested positive for COVID-19 and the entire household is quarantined, is the agency still responsible to provide the service?

Answer: Yes, essential services must be provided if PPE is available. If the client has someone in the home who has been trained to provide these services and is willing and able to do so, the agency can use this back-up arrangement *as long as it is documented*. Use of such a back-up scenario also should be discussed prior to implementation of an agency's emergency preparedness plan.

If PPE is not available and someone in the home cannot provide the service, the agency must document why the visit was not conducted. Also, the client's attending physician must be notified of the missed visit.