This document provides guidance to HCS residential providers on response actions in the event of a COVID-19 exposure.
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I. Purpose:

This document provides Home and Community-based Services (HCS) residential service providers with guidance in the event of a positive COVID-19 case associated with the program provider. HCS residential services are provided in host home/companion care (HH/CC) residences, three-person, or four-person residences. Three- and four-person residences are leased or owned by the program provider. This plan applies to residential services provided in three- and four-person residences, although HH/CC residences may find some of the guidance beneficial.

II. Goals:

- Rapid identification of COVID-19 situation in a HCS residence
- Prevention of spread within the residence
- Protection of individuals, staff, and visitors
- Provision of care for an infected individual(s)
- Recovery from an in-residence HCS COVID-19 event

III. Summary:

Recipients of long-term care (LTC) services are more susceptible to COVID-19 infection and the detrimental impact of the virus than the general population due to living in close proximity with others and their reliance on support from staff who often work on multiple shifts and in multiple locations. In addition to the susceptibility of individuals, an LTC environment presents challenges to infection control and the ability to contain an outbreak, with potentially rapid spread among a highly vulnerable population. These challenges can be exacerbated by shortages of staff and personal protective equipment (PPE).

This document provides service providers in HCS residences with immediate actions to take when they are made aware of potential infection of an individual, service provider, or essential visitor, as well as actions to take over the longer term.

IV. Description of an HCS Residence:

HCS is a Medicaid waiver program approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to §1915(c) of the Social Security Act. It provides community-based services and supports to eligible individuals as an alternative to the ICF/IID program. The program is limited to the number of
individuals in specified target groups and to the geographic areas approved by CMS.

Allowable HCS services include: transition assistance services; professional therapies; nursing services; residential assistance (excluding room and board); supported home living; respite; day habilitation; employment assistance; supportive employment; adaptive aids; minor home modifications; and dental treatment.

V. HCS Residences and COVID-19

Environment:

Since individuals receiving HCS program services have the right to live in a normative residential living environment, an HCS residence is integrated into the community and required to be typical of other residences in the community. These residential settings include a mix of semi-private and private individual bedrooms. Kitchens, bathrooms, and living areas are intended for use by both individuals and staff. The HCS environment extends to community settings such as day habilitation and work in the community through the inclusion of supported employment and employment assistance.

Impact of environment on COVID-19 response:

The relatively small size of a typical residence makes it challenging for providers to effectively support social distancing measures or accommodate quarantine measures including isolation. A single shared kitchen can pose infection control challenges when both residents and staff access the kitchen throughout the day.

The program provider can assist an individual who needs to isolate by moving dining and other activities, including medication administration, to their bedroom. Current state guidance states that communal activities, including dining, should be discouraged, and no more than 10 people, maintaining at least 6 feet of separation, be in a room at any time.

Program providers also have been advised not to send individuals to day habilitation and their places of employment to minimize exposure risk. In-home day habilitation services are temporarily approved for all individuals in the HCS program. Increased numbers of individuals staying home from day habilitation and employment can result in additional staffing needs for program providers and in emotional and behavioral challenges for individuals.
Residence Demographics:

HCS residences are located in urban, suburban, and rural locales, each of which has characteristics affecting workforce availability, health care system support, and interactions with public health, emergency care, and jurisdictional administration. Texas currently has 15,728 HCS residences in Texas.

Impact of demographics on COVID-19 response:

The industry as a whole, regardless of location, has experienced challenges in staff hiring and retention and in obtaining PPE. HCS residences in more densely populated locations are likely to experience higher risk for exposure among staff and visitors. As a result, residences in urban areas have a higher risk of infection and face more challenges controlling spread when there is infection. They also might face staffing shortages because of competitive job markets.

Residences in more rural locations have less health care system support, might not have local health authorities, and have smaller staffing pools, making it harder to cover shortages that result from presumptive exposure. Residences in rural areas might also be more challenged to find equipment, such as PPE, necessary to care for COVID-19 positive individuals.

Provider Considerations:

Residences differ in age, size, available space, and equipment. Services and the level of available care provided in a residence vary based on the needs of the individuals residing there. Ventilator support and specialized training of health care providers on-site will also vary.

Impact of provider considerations on COVID-19 response:

In some residences, the service provider will have few or no options to isolate an individual. The small maximum census of these residences limits the number of individuals for which each residence can provide care. An individual testing positive for COVID-19 will increase the need for staff and resources required to provide care, which can strain a residence, especially if other individuals with intensive personal care needs live there.
Individual Demographics:

Each individual receiving services in the HCS program is unique and has differing levels of disability, needs, and characteristics.

*Impact of individual demographics on COVID-19 response:*

All individuals need assistance from direct service providers and often clinical professionals who are in increasingly short supply as the pandemic continues. Depending on level of cognitive functioning, individuals might be unable to express when they experience symptoms and could unknowingly (and without staff knowing) spread the virus if infected.

This population also is less likely to understand why social distancing, the use of PPE, and quarantine are necessary and can present challenging behaviors when service providers attempt to enforce such restrictions. Other individuals require specialized medical care, including specialized diets, ventilator care, gastrostomy (feeding) tubes, and wound care for pressure sores. These specialized needs require a combination of skilled and non-skilled caregivers. Having COVID-19 infections in a residence will increase the demands on and for staff.

HCS Staffing Considerations:

The HCS workforce includes medical professionals and direct care service providers including: registered nurses (RNs), licensed vocational nurses (LVNs), direct service provider for residential and day habilitation services, behavior support staff and other skilled and non-skilled workers. The level of staffing required depends on each individual’s Person Directed Plan and Individual Plan of Care (IPC).

*Impact of HCS staffing considerations on COVID-19 response:*

Some individuals in the HCS program require partial or total assistance from staff for daily activities such as dining, bathing, grooming, and ambulating. Caring for someone with COVID-19 requires additional time and resources, including PPE, that maintain infection control and protect other individuals and staff. As service providers are exposed, become symptomatic or test positive for COVID-19, the available workforce will decline making it challenging for program providers to provide care.

HCS residences do not normally have a physician or nurse on-site. Typically, the individuals spend their time with direct service providers. Program providers often own multiple residences and share service providers between
these residences; therefore, if a service provider member has COVID-19, they may expose individuals and service providers in more than one residence, making it difficult to contain spread.

Visitors:

Since HCS residences are part of the community, visitors routinely enter the residence. Many perform essential services necessary for service delivery or to maintain the residence. The Governor’s Executive Order GA-18 requires residences to limit visitors to only those providing critical assistance. Provider Letter 20-22, issued March 20, 2020, and included as Appendix 3 to this document, also requires residences to limit visitors to only those who are providing critical assistance.

**Impact of visitors on COVID-19 response:**

Even with proper screening of essential visitors prior to allowing them to enter the residence, every person allowed inside increases the risk of infection. Some people will present as asymptomatic during screening but will have COVID-19 and unknowingly spread the virus. Some might not follow standard precautions such as proper hand-washing, use of hand sanitizer, use of PPE, isolation protocols, and limiting the number of areas in the residence that they access, all of which increases the risk of infection for individuals and service providers.

**VI. To Do’s for HCS Residences:**

**Isolation/quarantine:**
- *Isolation* refers to practices that separate persons who are sick to protect those who are not sick. *Quarantine* refers to practices that limit the movement of persons who have been exposed to infection for a period of time to see if they become sick.
- Review isolation/quarantine plans and use of PPE with service providers.
- To the extent possible, isolate those negative for COVID-19 from those who are positive or who have unknown COVID-19 status.
- Quarantine individuals with exposure or symptoms.

**Infection control:**
- Actively screen, monitor, and surveil everyone who comes into the residence. Document screening on a log, such as the one in Attachment 5. Limit non-critical visitors.
- Review handwashing, surface cleaning, and other environmental hygiene precautions with service providers.
• Clean and disinfect the residence thoroughly upon identifying a positive case.
• Educate individuals and any visitors regarding the importance of handwashing. Assist individuals in performing proper hand hygiene if they are unable to do so themselves. Educate individuals to cover their coughs and sneezes with a tissue, then throw the tissue away in the trash, and wash their hands.
• Comply with all CDC guidance related to infection control (program providers should frequently monitor CDC guidance, as it is being updated frequently. This will ensure the program provider is operating within the most current guidance).
• Comply with HHSC policies and practices, detailed in this document, related to infection control in accordance with GA-18.
• For the duration of the state of emergency, all HCS personnel must follow CDC and DSHS guidance related to wearing a facemask while they are in the residence.
• Obtain and properly use PPE. See Section VII below for more information.

Communication:
• Report every confirmed COVID-19 case to the local health department or DSHS. Providers must also report to HHSC.
• Coordinate individuals’ diagnoses and symptoms with transferring and receiving hospitals and other health care facilities.
• Communicate with individuals, service providers, and families when there is exposure or a confirmed case in the residence.

Staff precautions:
• Require service providers to self-monitor daily, including non-working days.
• Require service providers to report via phone prior to reporting for work if they have known exposure or symptoms. If symptomatic, staff should not report to work.
• To the extent possible, keep an up-to-date list of all service providers who work in other residences.
• To avoid transmission within residences, limit service providers from working at multiple residences if the service providers have worked in a residence where a resident has tested positive for COVID-19. In accordance with GA-18, minimize the movement of staff between residences wherever possible.
• Follow current CDC guidance on when and how staff recovering from COVID-19 can return to work. See Attachment 4.
VII. Use of PPE in HCS Residences

CDC guidance can be found here and here.

- To address asymptomatic transmission, the CDC recommends that providers consider implementing policies requiring everyone entering the facility to wear a cloth face covering (if tolerated) while in the building, regardless of symptoms. EXCEPTION: Face masks and cloth face coverings **should not** be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.

- A cloth face covering is appropriate for visitors performing critical assistance, as well as program provider staff when not caring for an individual with positive COVID-19 status.
  - If a person wearing a cloth face covering touches their face, they should be instructed to wash their hands after.
  - Individuals who are sick can take off the mask when in their own room but should put it on when others enter their room or when they leave their room.

- Cloth face coverings should be laundered daily or when they become soiled, damp, or hard to breathe through. Proper hand hygiene should be performed immediately before and after any contact with a cloth face covering.

- Individuals who are ill should wear a facemask as much as possible (unless contraindicated), except for when they are eating or drinking, taking medications, or performing personal hygiene like bathing or oral care.

- When caring for individuals with COVID-19, program provider staff should:
  - Follow standard precautions.
  - Use an N95 facemask or respirator (if available and if they have been trained and appropriately fit tested) rather than a cloth face covering or facemask.
  - Use eye protection.
o Use nonsterile, disposable gloves and isolation gowns, which are used for routine care in healthcare settings.

- After leaving the room of an individual with COVID-19, program provider staff can remove a facemask and store it for reuse. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

VIII.  S.P.I.C.E.

A potential COVID-19 situation in a residence can result in questions and confusion; this document suggests program providers focus on the following five basic actions (S.P.I.C.E.) to anchor their activities:

- **Surveillance** – monitor each individual at least daily (if well) or three times a day (if sick) for symptoms: fever, cough, shortness of breath, or difficulty breathing.
- **Protection/PPE** – protect workforce and individuals through the use of soap and water; hand sanitizer; facemask. If coughing or potential splash precautions are needed, wear a gown and face/eye shields. Refer to DSHS guidance.
- **Isolate** – isolate individuals with confirmed cases to the extent possible.
- **Communicate** – notify the local health department/authority or DSHS; notify HHSC.
- **Evaluate** – assess infection control processes, spread of infection and mitigation efforts, staffing availability.

S.P.I.C.E. is not meant to be all-encompassing. It is suggested to assist initial actions and be a reminder of necessary activities.

IX.  HHSC Activities with Program Providers that have Positive COVID-19 Cases

Waiver Survey and Certification (WSC) is notified each time a program provider reports a positive case. WSC begins outreach with the first notification and continues to be in communication until the case is resolved. If new cases arise, they are added to the WSC tracking and WSC continues outreach. As part of these outreach efforts, WSC will:

- Initiate desk reviews and outreach to program providers to conduct a focused review of infection control processes.
o Is the program provider prohibiting non-essential visitors?
o Review the program provider’s isolation plans. How are individuals isolated in the residence?
o Does the residence have sufficient amounts of PPE?
o Is the residence screening individuals and staff? How often?
o Are others (contract staff, family members) being screened?
o Is there a control or quarantine order? If so, is it being followed?
o Are program providers following rules and regulations related to enrollment, suspension, and termination, and ending suspension of individuals when appropriate?
o Are program providers notifying service providers, individuals, and families of positive COVID-19 cases in the residence?

- Begin tracking:
  o Number of individuals positive for COVID-19
  o Number of staff positive for COVID-19
  o Number of hospitalizations of individuals with COVID-19
  o Number of deaths of individuals with COVID-19
  o Program providers by number of positive cases

- Communicate with the local health department/local health authority and DSHS as warranted.
- Maintain communication with program providers after reviews are complete to obtain updates.

X. Program Provider Activities Required for COVID-19 Response

See Attachment 1 for additional guidance.

In Advance (actions focused on response)
- Review/create cohort plans (i.e., plans for grouping together persons with like COVID-19 status to limit transmission) for individuals
- Review infection control policies and procedures
- Review emergency plans and revise as needed
- Develop communication plan (external and internal)
- Conduct supply/resource evaluation
- Enact individual/service provider/visitor screening

Immediate (0-24 hours)
- Activate individual isolation/cohort plan
- Supply PPE to care for COVID-19 positive individuals
- Screen all individuals daily for signs and symptoms; screen individuals who are exhibiting symptoms three times a day to identify worsening symptoms that might require hospitalization
- Screen service providers for signs and symptoms
- Enact infection control policies and procedures
• Conduct cleaning and sanitation per CDC guidelines
• Report the positive diagnosis as required to state and local health departments, HHSC LTCR, and any others (e.g., organizational leadership)
• Activate all communication plans
• Determine need for restrictions/lock-down
• Supply resources/PPE and update resource evaluations
• Maintain individual care

Extended (24-72 hours)
• Supply PPE for individuals and service providers
• Screen all individuals daily for signs and symptoms; screen individuals who are exhibiting symptoms three times a day to identify worsening symptoms that might require hospitalization
• Continue infection control procedures
• Engage with external partners
• Determine need for restrictions/lock-down
• Consider medical/medication needs
• Maintain individual care

Long Term (72 hours plus)
• Screen individuals for signs and symptoms as noted above
• Continue cleaning and disinfection procedures
• Plan for lifting of restrictions (such as quarantine/isolation, social distancing, etc.)
• Consider ongoing medical/medication needs
• Maintain individual care

XI. State\Regional\Local Support

Texas Health and Human Services Commission (HHSC) will serve as the lead state agency in the state’s response to a COVID-19 event in the HCS program. HHSC actions will include:

• Development of testing recommendations, in consultation with DSHS
• Ensuring appropriate/assistance with individual movement
• Providing subject matter experts: Waiver Survey and Certification, healthcare acquired infections, epidemiology
• Coordination of HHSC, DSHS, emergency management and local actions
Glossary of Acronyms in Alphabetical Order

1. CDC – The Centers for Disease Control and Prevention
2. CMS – The Centers for Medicare and Medicaid Services
3. DSHS – Texas Department of State Health Services
4. EMS – Emergency medical services
5. EPA – Environmental Protection Agency
6. HA – Health authority
7. HAI – Health care associated infection
8. HCP – Health care personnel
9. HCS – Home and Community-based Services
10. HCW – Healthcare worker
11. HHSC – Texas Health and Human Service Commission
12. LHA – Local health authority
13. LHD – Local health department
14. LTC – Long-term care
15. LTCR – Long-term Care Regulatory
16. LVN – Licensed vocational nurse
17. NF – Nursing facility
18. OSHA – Occupational Safety and Health Administration
19. POC – Point of contact
20. PPE – Personal protective equipment
21. RN – Registered nurse
22. SME – Subject matter expert
23. TCAT – Texas COVID-19 Assistance Team
ATTACHMENT 1: Immediate Response Guidelines & Flowcharts

PROGRAM PROVIDER ACTIONS

Review *SPICE* activities.

**Prevent further disease spread**
- Determine number of individuals potentially infected
- Determine number of service providers potentially infected
- Identify if exposed service providers are working in other residences
- Determine who has been tested
- Invoke isolation precautions/plans
- If applicable, invoke quarantine or control order

**Protect from infection**
- Implement use of PPE in accordance with CDC and DSHS guidelines
- Assess PPE supplies
- Screen individuals/visitors
- Contact other residences where those exposed might have visited/worked
- Consult with your local health department (LHD) regarding testing
- Limit service providers in contact with those infected or exposed

**Care for individuals who are infected**
- Isolate individuals who are infected
- Group individuals: exposed, infected, negative
- Determine level of required care
- Maintain adequate supply of PPE
- Ensure disposal of used PPE in accordance with state/federal guidelines
- Maintain infection control, cleaning, and disinfection processes
- Determine if hospitalization is required
- Notify local health care/EMS
- Track signs/symptoms
- Work with state/local health department to plan for recovery – how and when the individual will reintegrate into the residence.

**Other**
- Follow all relevant regulations/rules
- Activate emergency response command structure
- Notify local health department/DSHS regional office/health authority
- Notify HHSC Waiver Survey and Certification
- Notify individuals, families/LARs, Local IDD Authority Service Coordinators, and service providers of individuals living in the residence
• Identify specific points of contact for communication with HHSC, local government, clinical staff, and the media
• Track tested, positive, isolated, quarantined, hospitalized, and deaths
• Maintain central database of external contacts and phone numbers

HHSC ACTIONS

Prevent further disease spread
• Conduct desk review and outreach
• Review program provider infection control practices
• Determine if service providers work at other residences, with other program providers, or at other health-care or long-term care facilities (such as state supported living centers)

Protect others from infection
• Review isolation precautions/plans
• Determine if residence has sufficient PPE
• Determine if residence has enacted screening for individuals/service providers
• Determine if quarantine order is in effect
• Ensure contact of other residences where exposed are working

Care for individuals who are infected
• Ensure appropriate isolation and quarantine
• Ensure timely individual care
• Ensure clinical support

Other
• Communicate updated guidance to program providers
• Review all relevant rules/regulations with program provider
• Track COVID-19 statistics related to the residence
• Identify points of contact and maintain communication
• Contact DSHS to review response activities
What can you do to identify a COVID-19 situation, help prevent the spread within a residence, and care for infected individuals?

**BEFORE THE FIRST CASE**
- PREPARE
  - SUPPLIES: Do you have enough? Stock up.
  - SCREEN: Start screening staff, individuals, and visitors.
  - ISOLATION PLAN: How will you isolate a sick individual?
  - INFECTION CONTROL policies & procedures: Review, revise, reflect CDC, DSHS & HHSC.
  - EMERGENCY PLAN: Review; adapt to COVID-19.

**IMMEDIATELY 0-24 HOURS**
- REACT
  - ACTIVATE response plans
  - CLEAN & SANITIZE
  - DEPLOY PPE for staff & individuals
  - REPORT to local health department/DSHS & to HHSC
  - ENHANCED MONITORING of signs & symptoms (daily for well individuals; 3x daily for sick individuals)
  - EVALUATE RESTRICTIONS: Is a lock-down needed?

**EXTENDED 24-72 HOURS**
- PROTECT
  - SUSTAIN supplies of PPE
  - EVALUATE RESTRICTIONS: Are they working?
  - MAINTAIN care & services
  - CONSIDER medical needs
  - CONTINUE enhanced monitoring signs & symptoms; cleaning & sanitizing; rigorous infection control

**LONG-TERM 72 HOURS+**
- TRANSITION
  - SUSTAIN your response
  - EVALUATE: What is/isn't working?
  - LOOK AHEAD: How will you lift restrictions safely?
ISOLATION PLANNING IN HCS RESIDENCES

PRIOR TO COVID-19 Diagnosis

The time to begin planning is BEFORE an individual is diagnosed with COVID-19.

WHERE will you isolate a COVID + individual?

- Is there a room you can repurpose?
- Can you make an arrangement with another residence?

WHO will provide care?

- Can you dedicate certain staff to provide care?
- Keep staff who provide care to individuals with COVID-19 from working at other residences if possible.

HOW will you ensure infection control?

- Train staff on infection control.
- Provide hygiene supplies and PPE.
Upon COVID-19 Diagnosis

MOVE individual's personal belongings to designated area

TRANSFER individual to designated area

NOTIFY local health department or DSHS; notify HHSC

TEST all individuals and staff
After Recovery

- CLEAN & DISINFECT individual's personal belongings
- TRANSFER individual & belongings out of isolation
- MONITOR individual for signs/symptoms
- CLEAN & DISINFECT isolation room
ATTACHMENT 2: SPICE Graphic

**SPICE**
for COVID-19

**Surveillance**
- Signs and symptoms
- Temperature checks
- Individuals/staff/visitors
- Testing

**Protection/Personal Protective Equipment**
- Clinical staff
- Support staff
- Individuals
- Supply/burn rate

**Isolate**
- Individual(s) isolated
- Staff isolated
- Others isolated

**Communicate**
- CEO contact #:
- Local health department #:
- DSHS #:
- HHSC TCAT #:
- Hospital #:

**Evaluate**
- Review 0-24 hour checklist
- Prevent delay of critical actions
- Communication plan
ATTACHMENT 3: Current Guidance for HCS Providers from Provider Letter 20-22

1.0 Subject and Purpose

HCS and TxHmL program providers are required to comply with state and federal, laws, rules, regulations, and letters regarding the HCS and TxHmL programs. Due to the escalating situation of the COVID-19 (coronavirus), the Texas Health and Human Services Commission (HHSC) is issuing the following guidance to program providers to reduce the risk of spreading the virus to individuals served. This revised guidance is based on additional direction from Governor Abbott and the Department of State Health Services.

Based on Executive Order GA-08, people will no longer be allowed to enter HCS or TxHmL homes except to provide critical assistance to individuals. Persons with a legal right to enter the home may only do so to address a critical need.

Essential visitors who are there to provide critical assistance include provider staff and other contract care providers and persons with legal authority to enter, provided their visit is for the purpose of providing critical assistance to individuals. The program provider must continue to staff the home and ensure critical needs are met. Program providers must have a service backup plan for all critical program services; the provider may use that plan as a guide in determining critical assistance.

All visitors should be screened as described below and practice hand hygiene prior to and during the visit.

During this time, HCS and TxHmL providers should provide alternate means of communication for people who would otherwise visit, such as virtual communications (e.g. video or telephone conferencing systems) to promote ongoing contact between individuals and their loved ones.

Screening of Essential Visitors Providing Critical Assistance
Essential visitors providing critical assistance may be allowed access unless they meet the following screening criteria:

- Fever or signs or symptoms of a respiratory infection, such as cough, shortness of breath, or sore throat;
- 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; or
- Traveled within the previous 14 days to a country with sustained community transmission. For updated information on affected countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html

Program providers should take precautions and screen all visitors to ensure they do not meet the above criteria.
2.0 Policy Details & Provider Responsibilities

Individuals receiving services from an HCS or TxHmL provider typically have the right to receive visitors. However, all individuals in the home also have the right to live in a healthful and safe environment. Furthermore, the program provider has an overarching responsibility to ensure the health and safety of all individuals in the home. As such, until notified otherwise, HHSC is issuing the following guidance:

1. Program providers should follow guidance issued by:
   a. The Centers for Disease Control (CDC)
   b. The Department of State Health Services (DSHS)
   c. The Health and Human Services Commission (HHSC)
   d. Their local public health department

2. Program providers are already required to implement personnel practices that safeguard individuals against the spread of infectious disease. Providers should ensure that they have processes in place to reduce the spread of communicable and infectious diseases and that those processes are updated to align with CDC guidance. These processes should address the use of personal protective equipment (PPE).

3. Program providers must have PPE available. If they are unable to obtain PPE, they will not be cited for not having certain supplies if they cannot obtain them for reasons outside of their control. Follow national guidelines for optimizing current supply or identify the next best option to care for the individuals.

4. Program providers should protect individuals by refraining from attending day habilitation, and events in public where more than 10 people are gathered. Communal dining and all group activities should also be canceled.

5. Program providers must have continuous availability of trained and qualified service providers to provide oversight to individuals while they remain in their homes.

6. Program providers should limit visitors to individuals’ residences to persons providing critical assistance, who meet screening criteria specified below in item 10.

7. All residences should have visible signage at the entrances to address the screening criteria below prior to allowing access to individuals. Signage should also include language to discourage visits, such as recommending visitors defer their visit for another time or to list exceptions such as essential personnel as mentioned above. The signage should remain in place until further guidance is issued by HHSC.

8. Program providers must disinfect the area following a visitor’s exit from the location.

9. Program providers should offer alternate means of communication during this time of limited visitation, such as:
   a. Phone calls, video calls, or other means of electronic communication
   b. Offering a phone line with voice recording updated at set times (e.g. daily) with the provider’s general operating status, such as when it is safe to resume visits

10. Program providers must actively and consistently monitor individuals for potential symptoms of respiratory infection. They must ensure the nurse is notified immediately of any individuals who begin exhibiting symptoms such as fever, cough, or shortness of breath. Nurses must notify the individual’s physician immediately.

11. Program providers must contact their local health department, or DSHS if there is no local health department, if:
a. there are questions related to COVID-19,
b. they suspect an individual has COVID-19,
c. there is an increase in the number of respiratory illnesses among individuals or service providers.

12. Program providers must ensure that all host homes, three-person, and four-person residences are equipped with soap, hand sanitizer, and any other disinfecting agents to maintain a healthful environment.

13. Within residences, provider staff must ensure precautions such as, but not limited to:
   a. Limiting physical contact, such as handshaking, hugging, etc.
   b. Reinforcing strong hygiene practices for individuals and staff, such as proper handwashing, covering of coughs and sneezes, and the use of hand sanitizer
   c. Practicing social distancing as defined by CDC.
   d. Using gloves when supporting individuals
   e. Regularly disinfecting all high-touch surfaces, such as counters, doorknobs, telephones, etc.

14. Program providers must ensure their HCS program has an Emergency Preparedness Plan that addresses all required elements.

3.0 Background/History
Program providers have the responsibility to protect the health and safety of individuals under their care at all times. State and federal guidance indicates that COVID-19 presents a health and safety risk to individuals receiving HCS and TxHmL services. The best method of protecting them from infection is to keep the infection out of the home.

4.0 Resources
Department of State Health Services COVID-19: Guidance for Public Health Home Service Providers.


5.0 Contact Information
If you have any questions about this letter, please contact the Policy, Rules and Training Section by email at PolicyRulesTraining@hhsc.state.tx.us or call (512) 438-3161.
ATTACHMENT 4: Return-to-Work and End-of-Isolation Flowcharts

TEST-BASED STRATEGY FOR HEALTHCARE PERSONNEL
RETURN TO WORK (Preferred)
Adapted from the Tennessee Department of Health

SYMPTOMATIC CASES
Must be isolated and excluded from work until afebrile (without the use of fever reducing medications) and with improvement of respiratory symptoms, and after receiving negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).

Onset date
Afebrile with improvement of symptoms
First negative specimen
Case released from isolation and may return to work

ASYMPTOMATIC CASES
Must be excluded from work until 10 days have passed since the date of the first positive test, assuming they have not subsequently developed symptoms since the positive result.

If the HCP develops symptoms, they should self-isolate and use follow instructions above for "symptomatic cases."

ADDITIONAL INFORMATION
There may be additional requirements for HCP to be cleared to return to work at their healthcare facility.

After returning to work, symptomatic and asymptomatic HCP should:
• Wear a medical facemask (and not a cloth face covering) for source control at all times while in the healthcare facility until all symptoms are completely resolved OR until 14 days after illness onset or positive result, whichever is longer.
• Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematologic-oncology) until 14 days after illness onset or positive result.
• Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms occur, recur, or worsen.
TEST-BASED STRATEGY (PREFERRED):
When to End Isolation of an Individual with COVID-19

The individual must be isolated until:

No fever (with no fever-reducing medications)

AND

Improved respiratory symptoms

AND

2 negative approved COVID-19 tests collected at least 24 hours apart

RELEASE FROM ISOLATION

1st negative test

2nd negative test (at least 24 hours later)

NON-TEST-BASED STRATEGY:
When to End Isolation of an Individual with COVID-19

Isolated AT LEAST 10 days from onset of symptoms

AND

No fever for 72 hours without use of fever-reducing medication

AND

Improved respiratory symptoms

RELEASE FROM ISOLATION

Symptoms begin or date of COVID test

\[ \leftrightarrow 10 \text{ days} \]

Symptoms improve; no fever for at least 72 hours
ATTACHMENT 5: Sample Symptom Monitoring Log for HCS Residences

COVID-19 Symptom Monitoring Log for HCS Residences

Instructions: Screen all staff at the beginning of their shift. Actively take their temperature and document shortness of breath, new or change in cough, and sore throat. Mark the symptoms below with 'Y' for Yes if present and 'N' for No if absent. Don’t leave any spaces blank. If temperature is greater than 100.0° F or any symptom is marked Y, direct staff to put on a facemask and leave the workplace.

DATE: _______________

<table>
<thead>
<tr>
<th>NAME</th>
<th>TIME</th>
<th>°F</th>
<th>Shortness of breath?</th>
<th>New/Change in Cough?</th>
<th>Sore throat?</th>
<th>Exposure?</th>
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ATTACHMENT 6: Extended Response Guidelines (To Be Developed)
ATTACHMENT 7: Recovery Guidelines (To Be Developed)