Chicago Department of Public Health

Health Alert

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CHICAGO DEPARTMENT OF PUBLIC HEALTH

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UPDATED Guidance for Outpatient Healthcare Facilities

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Summary and Action Items

- COVID-19 molecular testing is now recommended for all patients seeking care who are symptomatic, even those with mild symptoms (See April 30, 2020 Health Alert: *Recommendations for Health Care Providers to Test All Patients with Acute Respiratory Illness for COVID-19*).
- CDC has also updated testing priorities: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html and isolation period recommendations: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html.
- Given this change, CDPH has summarized the most recent CDC infection control guidance to support outpatient operations, including the following key elements:
  - **Reduce facility risk.** Use telemedicine when possible, limit points of entry and manage visitors, screen everyone entering the facility for COVID-19 symptoms, implement source control for everyone entering the facility, regardless of symptoms.
  - **Isolate symptomatic patients as soon as possible.** Set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with the door closed.
  - **Protect healthcare personnel.** Emphasize hand hygiene, train frequently on appropriate use of PPE, install barriers to limit contact with patients at triage, consider outdoor testing and triage capabilities, follow new return to work guidance for healthcare personnel.
  - **Report positive test results to public health** by methods described in April 29, 2020 Public Health Order.

Background: Outpatient healthcare settings should review the UPDATED Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings and UPDATED Centers for Disease Control and Prevention (CDC) Infection Control FAQs. Relevant content related to outpatient settings includes guidance on ways to minimize chance for exposures, adhering to standard and transmission-based precautions, collection of diagnostic respiratory specimens, managing visitor access and movement within the facility, implementing environmental infection control, monitoring/management of healthcare personnel (HCP) and ensuring reporting within and between healthcare facilities and to public health authorities. In addition, CDC has guidance on Outpatient and Ambulatory Care Settings: Responding to Community Transmission of COVID-19 in the United States including ways to reduce crowding in waiting rooms, consider asking patients waiting to be seen to remain outside (e.g., stay in their vehicles, if applicable) until they are called into the facility for their appointment or set up triage booths to screen patients safely, delay elective ambulatory provider visits and continuing to implement alternative service delivery models such as telemedicine. Recommendations will change over time as local epidemiology changes.

Considerations for Collection of Diagnostic Respiratory Specimens

Some specimen collection guidance has changed since April 29, 2020 in which additional specimen sources are allowed and the preference for nasopharyngeal swabs has been removed. Nasal mid-turbinate (NMT) swab in both nares, also called Deep Nasal Swab are now allowable. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab or deep nasal swab) from a patient with possible COVID-19, the following should occur:

- Specimen collection should be performed in a normal examination room with the door closed.
- HCP in the room may wear a facemask, eye protection, gloves, and a gown.

- N95 respirators should be prioritized for other procedures at higher risk for producing infectious aerosols (e.g., intubation), instead of for collecting nasopharyngeal swabs.
- The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for specimen collection.
- To request COVID-19 testing supplies including Nasopharyngeal swabs (NP), Anterior nare swabs (N), transport media, ice packs, shipping boxes with coolers, UPS return service labels, UN3373 shipping labels and biohazard bags use the online IDPH online request form: https://app.smartsheet.com/b/form/23f8f4130df043568f2e92169b8cda40.

Outpatient Environmental Infection Control Tips

- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings.
  - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2.
- Clean and disinfect procedure room surfaces promptly after diagnostic respiratory specimens obtained. In general, only essential personnel should enter the room of patients with suspected or confirmed COVID-19.
- Although spread of SARS-CoV-2 is believed to be primarily via respiratory droplets, the contribution of small respirable particles to close proximity transmission is currently uncertain. Airborne transmission from person-to-person over long distances is unlikely.
- The amount of time that the air inside an examination room remains potentially infectious is not known and may depend on a number of factors including the size of the room, the number of air changes per hour, how long the patient was in the room, if the patient was coughing or sneezing, and if an aerosol-generating procedure was performed. Facilities will need to consider these factors when deciding when the vacated room can be entered by someone who is not wearing PPE.
  - For a patient who was not coughing or sneezing, did not undergo an aerosol-generating procedure, and occupied the room for a short period of time (e.g., a few minutes), any risk to HCP and subsequent patients likely dissipates over a matter of minutes. However, for a patient who was coughing and remained in the room for a longer period of time or underwent an aerosol-generating procedure, the risk period is likely longer.
  - For these higher risk scenarios, it is reasonable to apply a similar time period as that used for pathogens spread by the airborne route (e.g., measles, tuberculosis) and to restrict HCP and patients without PPE from entering the room until sufficient time has elapsed for enough air changes to remove potentially infectious particles.
- HCP already in PPE or Environmental Services (EVS) personnel may enter the room after sufficient time has elapsed, depending on the use of the room as above, and should wear a gown and gloves when performing terminal cleaning. HCP/EVS personnel should clean and disinfect environmental surfaces and shared equipment before the room is used for another patient.
  - A facemask (if not already wearing for source control) and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated. Shoe covers are not recommended.

Considerations for Protecting and Managing Healthcare Personnel (HCP)

Many facilities have already experienced staffing shortages due to HCP exposures, illness, or need to care for family members at home. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information. As part of this, asymptomatic HCP with a recognized COVID-19 exposure might be permitted to work as a crisis capacity strategy to address staffing shortages if they wear a facemask for source control for 14 days after the exposure. This time period is based on the current incubation period for COVID-19 which is 14 days. Plans and processes to mitigate staffing shortages can always be improved and current recommendations are described below.

- Facilities and organizations providing healthcare should implement sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance.
- As part of routine practice, HCP should be asked to regularly monitor themselves for fever and symptoms of COVID-19. HCP should be reminded to stay home when they are ill.
- Screen all HCP at the beginning of their shift for fever and symptoms consistent with COVID-19*

    - Actively take their temperature and document absence of symptoms consistent with COVID-19*. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
    - *Fever is either measured temperature >100.0°F or subjective fever. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be warranted for lower temperatures (<100.0°F) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by occupational health.
- If HCP develop fever (T≥100.0°F) or symptoms consistent with COVID-19* while at work they should keep their cloth face covering or facemask on, inform their supervisor, and leave the workplace.
- HCP with suspected COVID-19 should be prioritized for testing. See updated CDC guidance (April 27, 2020) on Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) as well as April 30, 2020 Health Alert: *Recommendations for Health Care Providers to Test All Patients with Acute Respiratory Illness for COVID-19*.
- Healthcare facilities should consider foregoing contact tracing at this phase of the pandemic in favor of universal source control for HCP and screening for fever and symptoms before every shift.

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19

CDC recommends new criteria for return to work for HCP with confirmed or suspected COVID-19 which include a symptom-based strategy (preferred for symptomatic), time-based strategy (preferred for asymptomatic) or a test-based strategy. Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture. Detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Symptomatic HCP with suspected or confirmed COVID-19:

- *Symptom-based strategy* (**preferred**). Exclude from work until:
    - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**, At least 10 days have passed *since symptoms first appeared*
- *Test-based strategy.* Exclude from work until:
    - Resolution of fever without the use of fever-reducing medications **and** Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and** Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms:

- *Time-based strategy* (**preferred**). Exclude from work until:
    - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used.
        - Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.
- *Test-based strategy*. Exclude from work until:
    - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

After returning to work, HCP should: Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic. Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.

Discontinuation of Isolation for Persons with COVID-19 in Non-Congregate and Congregate Settings

On May 3, 2020, additional CDC recommendations on Disposition of Patients with COVID-19 in the Community (Interim Guidance) were posted with a preference for symptom-based strategy of at least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and, at least 10 days have passed since symptoms first appeared.