COVID-19 Infection Prevention and Control for Outpatient Clinics
Frequently Asked Questions (FAQs)

TMA COVID-19 Task Force
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What can you do to minimize exposure to COVID-19 in your clinic? (CDC, 5/18/2020)

Basic steps before a potential patient with COVID-19 visits your clinic:

1. When scheduling appointments for routine medical care, inform all patients they must call ahead and discuss the need to reschedule their appointment if they develop fever, cough, or other symptoms of COVID-19 on the day they are scheduled to be seen.

2. When scheduling appointments for patients requesting evaluation for possible COVID-19, use nurse-directed triage protocols to determine if an appointment is necessary or if the patient can be managed from home. If the patient must come in for an appointment, instruct them to call ahead to inform triage personnel if they have symptoms of COVID-19 and take appropriate preventive actions. Refer to the CDC COVID-19 phone script, which includes both a decision algorithm and messages for addressing possible COVID-19 patients. (CDC, 3/30/2020)

3. Consider offering and implementing telemedicine services for your patients, in order to provide your patients the care they need while maintaining social distancing. (CDC, 3/20/2020) For more information on telemedicine, visit TMA's telemedicine page.

4. Advise patients and visitors entering the clinic, regardless of symptoms, to put on a cloth face covering or face mask (if tolerated) before entering the building and screen for fever and symptoms of COVID-19. Face masks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

5. Consider limiting points of entry to the clinic and allowing only the patient into the clinic exam room. Consider requesting that accompanying family members wait in their vehicles and be updated as necessary by phone.

Steps when evaluating a patient suspected to have COVID-19:

1. Post signs and posters at the entrance and in strategic places (e.g., waiting area, bathroom) to provide patients and staff with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette.
2. Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand sanitizer with 60% to 95% alcohol, tissues, and no-touch receptacles for disposal at entrance, waiting room, and patient check-in.

3. Consider installing physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between staff and potentially infectious patients. Also consider establishing triage stations outside your clinic to screen patients before they enter.

4. If possible, bypass the waiting room or do not allow the patient to remain in the waiting area or other common areas. In some settings, patients might opt to wait in a personal vehicle or outside the health care facility where they can be contacted by phone when it is their turn to be evaluated. Implement social distancing practices in the waiting room, such as placing waiting room chairs six feet apart.

5. If medical evaluation of a patient with acute respiratory illness is necessary, but not urgent, try to schedule the patient at the end of the day.

6. Ask patients with respiratory illnesses to alert you before entering the facility and provide them a surgical mask before entry. If a surgical mask is unavailable, ask the patient to use other practical means of source containment such as a tissue to contain respiratory secretions during transit through common areas.

7. Place the patient in a single-person room with the door closed. Patients with acute respiratory symptoms must be considered potentially infected with COVID-19, and thus should remain in the same room for the duration of their stay in the facility (e.g., minimize room transfers), to the extent possible. Minimize the number of staff entering the room.

8. Maintain proper infection control when collecting specimens for diagnostic testing for COVID-19. In outpatient settings, a nasopharyngeal specimen can be collected in a normal examination room with the door closed. Health care personnel in the room should wear a N95 or higher respirator (or a face mask if respirators are unavailable), eye protection (e.g., face shield or goggles), gloves, and gown.

9. After a patient with suspected COVID-19 has left an exam room, health care personnel, patients, and environmental services personnel should not enter the vacated room for at least one hour. This allows sufficient time to elapse for enough air changes to remove potentially infectious particles. See CDC Guidelines for Environmental Infection Control in Health-Care Facilities for more information. (CDC, 7/22/2019)

10. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before resuming routine use.

**What other types of infection prevention control measures do I need to implement in my clinic? (CDC, 5/18/2020)**

1. Remind staff to always practice **standard precautions** (assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the health care setting) and also use transmission-based precautions when seeing patients with respiratory symptoms. This means:

   - **Hand hygiene** – Ensure proper hand hygiene (using alcohol-based hand sanitizer with 60% to 95% alcohol or washing hands with soap and water for at least 20 seconds) before and after all patient contact, contact with potentially infectious material, and before putting on and after removing personal protective equipment (PPE), including gloves. Clinics should ensure that hand hygiene supplies are readily available to all personnel.
• **Personal protective equipment** – Ensure staff training and availability of personal protective equipment recommended when caring for a patient with known or suspected COVID-19. This includes:

  - N95 or higher-level respirator (or a face mask if respirators are unavailable; for more information, refer to the CDC [infographic](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-hospitals/ppe-supply-shortage.html) and TMA’s [PPE Supply and Shortage FAQs](https://www.tma.org/PPE-Supply-and-Shortage-FAQs)). Higher level respirators include other disposable filtering facepiece respirators, powered air purifying respirators, or elastomeric respirators. Of note, N95 or other respirators with an exhaust valve might not provide source control. N95 respirators or higher-level respirators should be used instead of a face mask when performing or present for an aerosol generating procedure. ([CDC](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-hospitals/ppe-supply-shortage.html), 5/18/2020);
  
  - Eye protection (such as goggles or a disposable face shield);
  
  - Gloves (clean, non-sterile, disposable); and
  
  - Gowns.

More details on PPE:

  - Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Health Care Settings
  
  - How to properly put on, use, and remove PPE
  
  - Strategies for Optimizing Supply of N95 Respirators

Strictly follow basic infection control practices between patients (e.g., hand hygiene, removal and discarding of disposable PPE, cleaning and disinfecting shared equipment).

**What cleaning procedures should you follow to disinfect the area exposed to someone with viral respiratory symptoms or potentially exposed to SARS-CoV-2 (the virus that causes COVID-19)?** ([CDC](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-hospitals/cleaning-disinfection.html), 5/18/2020)**

1. Once the patient leaves the clinic, all staff should refrain from entering the vacated room until at least one hour has elapsed for enough air changes to remove potentially infectious particles. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use. ([CDC](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-hospitals/cleaning-disinfection.html), 7/22/2019)

2. Routine cleaning and disinfection procedures with an Environmental Protection Agency (EPA)-registered, hospital-grade disinfectant are appropriate for SARS-CoV-2 in health care settings. Refer to [List N](https://www.epa.gov/agents/sars-cov-2-disinfectants) on the EPA website for EPA-registered disinfectants that have qualified under EPA’s emerging viral pathogens program for use against SARS-CoV-2.

3. Management of laundry and medical waste should also be performed in accordance with routine procedures. Additional information about recommended practices for terminal cleaning of rooms and PPE to be worn by environmental services personnel is available in the [Healthcare Infection Prevention and Control FAQs for COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-hospitals/cleaning-disinfection.html).
How can I best prepare my staff? (CDC, 5/18/2020)

1. Facilities and organizations providing health care should implement sick leave policies for staff that are non-punitive, flexible, and consistent with public health guidance.

2. As part of routine practice, health care personnel (HCP) should be asked to regularly monitor themselves for fever and symptoms of COVID-19. Decisions about work restrictions, voluntary quarantine, and health monitoring for staff with exposure to COVID-19 should be made in consultation with public health authorities. Refer to your local health department or the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) for additional information.

3. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Health care facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing resources to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are available.

4. Provide staff with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.

5. Ensure all staff are educated, trained, and have practiced the appropriate use of necessary PPE prior to caring for a patient with possible COVID-19, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

What infection prevention and control precautions should I be taking if I think a patient with possible COVID-19 requires a higher level of evaluation at an emergency department (ED)?

1. Do not send patients to your local or state health department offices.

2. Call ahead to the receiving ED facility to notify it of a possible diagnosis so its staff is prepared to triage the patient quickly into an appropriate room.

3. Encourage the patient to self-transport by private vehicle if feasible. Patient should not take a ride-share service (e.g., Uber, Lyft).

4. If emergency medical services (EMS) transport is required, ensure the receiving EMS responders are also aware of the possible diagnoses of COVID-19.

What infection prevention and control recommendations should I give to patients with suspected COVID-19 if I feel they are well enough to go home? (CDC, 3/20/2020)

1. People who are medically stable and who do not require hospitalization or are discharged home following a hospitalization with confirmed COVID-19 infection are advised to isolate at home and restrict activities outside their home, except for getting medical care. Inform patients undergoing home care that:
   
   - Household members, intimate partners, and caregivers who may have close contact with a person with symptomatic, laboratory-confirmed COVID-19 or a person under investigation should monitor their health and call their physician right away if they develop symptoms suggestive of COVID-19 (e.g., fever, cough, shortness of breath).
• Household members should stay away from the sick patient as much as possible and use a separate bedroom and bathroom, if available.

• The patient should wear a cloth face covering over his or her nose and mouth around other people and prohibit nonessential visitors.

• The patient should not handle pets or other animals while sick. For more information, see COVID-19 and Animals.

• The patient should perform hand hygiene frequently, avoid sharing household items, clean all high-touch surfaces, and wash laundry thoroughly.

See Preventing the Spread of Coronavirus Disease 2019 in Homes and Residential Communities (CDC, 5/24/2020), which includes recommendations for household members and caregivers of patients with suspected or confirmed COVID-19.

2. Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation under the following conditions:

• At least 24 hours have passed since recovery – defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); and

• At least ten days have passed since symptoms first appeared.

3. Persons who have with no symptoms but tested positive may discontinue home isolation after 10 days have passed since their positive test (assuming no symptoms develop in that time).

For more information, see Discontinuation of Home Isolation for Persons with COVID-19 (Interim Guidance 7/20/2020).

What are criteria for returning to work for health care personnel with confirmed or suspected COVID-19? (CDC, 7/17/2020)

Use one of the strategies below to determine when health care personnel may return to work in health care settings.

1. Symptom-based strategy: Exclude from work until:

   • For HCP with mild or moderate illness who are not severely immunocompromised:

     ° At least 24 hours have passed since recovery, defined a resolution of fever without the use of fever-reducing medications;

     ° Improvement in symptoms (e.g., cough, shortness of breath); and

     ° At least 10 days have passed since symptoms first appeared.

     **HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.**

   • For HCP with severe to critical illness or who are severely immunocompromised:

     ° At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications;
° Improvement in symptoms (e.g., cough, shortness of breath); and

° At least 20 days have passed since symptoms first appeared.

_HCP who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test._

2. **Test-based strategy:**

- A test-based strategy is _no longer recommended_ because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

- In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

- The criteria for the test-based strategy are as follows.

  ° For HCP who are symptomatic:

    - Resolution of fever without the use of fever-reducing medications,

    - Improvement in symptoms (e.g., cough, shortness of breath), and

    - Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using a Food and Drug Administration (FDA)-authorized molecular viral assay to detect SARS-CoV-2 RNA.

  ° For HCP who are not symptomatic: Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

After returning to work, health care personnel should:

- Always wear a face mask while in the health care facility until all symptoms are completely resolved or at baseline;

- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in [CDC’s interim infection control guidance](https://www.cdc.gov/coronavirus/2019-ncov/community/infection-control-guidance.html) (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles); and

- Self-monitor for symptoms and seek reevaluation from occupational health if symptoms recur or worsen.
For other questions not addressed by this FAQ, please refer to TMA’s other FAQ pages on COVID-19 or contact:

CDC Coronavirus COVID-19 website

DSHS Coronavirus Disease (COVID-10) website

DSHS COVID-19 Call Center: **2-1-1 Option 6**, Monday-Friday, 7 am-8 pm

DSHS email: [coronavirus@dshs.texas.gov](mailto:coronavirus@dshs.texas.gov)

TMA Knowledge Center (800) 880-7955 or [knowledge@texmed.org](mailto:knowledge@texmed.org)

TMA COVID-19 Resource Center: [texmed.org/Coronavirus](http://texmed.org/Coronavirus)

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