Interim CDC Guidance on Handling Non-COVID-19 Public Health Activities that Require Face-to-Face Interaction with Clients in the Clinic and Field in the Current COVID-19 Pandemic

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Audience: Managers and their staff engaged in public health clinic settings and field outreach activities in state and local health departments.

Purpose: To provide guidance for the management of public health workers engaged in public health activities that require face-to-face interaction with clients in clinic and field settings. These activities would include prevention and control programs for TB, STDs, HIV, and other infectious disease activities that would require outbreak or contact investigation, home visits, or partner services, and non-infectious disease-specific programs, e.g., syringe services programs, or occupational health activities.

Overview

The Coronavirus Disease 2019 (COVID-19) global pandemic has forced public health to reassess its approach to providing care while keeping staff and patients safe. Mitigation strategies, such as social distancing and sheltering in place, have impacted clinical care and field services across the nation. As a result, many jurisdictions have limited face-to-face interactions to only the most essential.

It is important to protect healthcare and public health workers from COVID-19 while maintaining their ability to deliver critical public health services. State, local, tribal, and territorial public health programs need flexibility to reassign tasks and shift priorities to meet these competing needs. This document provides guidance for protecting public health workers engaged in public health activities that require face-to-face interaction with clients in clinic and field settings. The guidance has the following objectives:

- minimizing risk of exposure, illness, and spread of disease among staff conducting public health emergency response operations and essential public health functions;
- minimizing risk of exposure, illness, and spread of disease among members of the public at public health facilities; and
- preserving essential functions and mission capabilities of state, territorial, local, and tribal health departments.

Prioritization

Activities that should receive highest priority will vary with the level of community COVID-19 transmission, characteristics of the priority populations to be served, local capacity to implement effective prevention and control activities, and availability of effective interventions. Points to consider include:

- The US Centers for Disease Control and Prevention (CDC) updates guidance as needed and as additional information becomes available. Please check the CDC COVID-19 website periodically for updated guidance.
- Activation of federal emergency plans may provide additional authorities and coordination needed for interventions to be implemented. State and local laws and declarations may impact how resources can be appropriated and allocated and staff reassigned. Section 319(e) of the Public Health Service (PHS) Act authorizes states and tribes to request the temporary reassignment of state, territorial, local, or tribal public health department or agency personnel funded under federal programs as authorized by the PHS Act when the Secretary of the Department of Health and Human Services (HHS) has declared a public health emergency. For more details: https://www.phe.gov/Preparedness/legal/pahpa/section201/Pages/default.aspx
- When developing prioritization plans, health departments should identify ways to ensure the safety and social well-being of staff, including front line staff, and staff at increased risk for severe illness.
- Activities may vary across settings (clinical vs nonclinical) and by type of staff (office staff, physicians, nurses, disease intervention specialists (DIS), etc.) based on identified critical needs/services established by the health department and local authorities.
- Depending on the level of community spread, public health departments may need to implement prioritization and preservation strategies for public health functions for identifying cases and conducting contact tracing. For HIV, TB, STD, and Viral Hepatitis prevention and control programs, recommended prioritization strategies based on level of community spread are presented as an **Appendix** to this document.

Phased Approaches and Strategies for Face-to-Face Activities

Consistent with CDC's guidance for implementation of prevention strategies for communities with local COVID-19 transmission (see community mitigation strategy), this adapted table lays out two sets of strategies that public health departments should use based on the current level of COVID-19 community transmission.

None to Minimal Transmission*	Minimal to Substantial Transmission
Evidence of isolated cases or limited community transmission, case investigations underway, continued open capacity of hospitals and urgent care centers.	Minimal to moderate: Widespread and/or sustained transmission to large scale community transmission, with high likelihood or confirmed exposure within communal settings and potential for rapid increase in suspected cases. Substantial: Large scale community transmission, healthcare staffing significantly impacted, multiple cases within communal settings like healthcare facilities, schools, mass gatherings etc.
• Identify critical public health activities • Plan for discontinuation of non-essential public health activities • Plan for implementation of flexible work (e.g., telework) and sick leave policies	• Discontinue non-essential public health activities • Encourage telework options for staff when possible • Encourage strict use of respiratory protection

• Implement triage prior to entering facilities to rapidly identify and isolate patients with respiratory illness (e.g., phone triage before patient arrival, triage upon arrival) • Isolate patients exhibiting symptoms of COVID-19 • Develop alternate telemedicine practices for patients exhibiting symptoms of COVID-19 or other infectious diseases • Within health department settings, implement social distancing measures, and encourage increased hand hygiene (access to soap and water and alcohol-based hand sanitizer, tissues), encourage respiratory hygiene (face masks and respirators), increased cleaning and disinfection	and other PPE in situations that require working with clients in close proximity (including during patient visits, specimen collection, DIS field visits) • Encourage strict implementation of phone triage and telemedicine practices where possible • Isolate patients exhibiting symptoms of COVID-19 • Implement social distancing practices (e.g., placing tape on floors to establish proper spacing between people)

*Assuming there is adequate availability of quality diagnostic information. In the absence of such information, other sources of judgement should be sought, such as local public health officials, hospital guidance, or local health care providers.

Consideration of Worker Risk Level

Workers' risk of occupational exposure may vary based on the nature of their work. Public health programs should assess potential risk for exposure to the virus that causes COVID-19, especially for those staff whose job functions require working with clients in close proximity and in locations where there is known community transmission. While not all public health staff fall into the category of healthcare personnel (HCP), conducting medical exams or specimen collection procedures where risk of exposure is high, many public health activities for disease prevention and intervention involve face-to-face interactions with patients, partners, and organizations, putting public health staff at risk for acquiring COVID-19.

Per CDC guidance (see https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html), close contact is defined as: a) being within approximately 6 feet (2 meters) of a person with COVID-19 for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a person with COVID-19, – or – b) having direct contact with infectious secretions of a person with COVID-19 such as being coughed on.

Public health staff should wear appropriate PPE for the job function that they are performing, in accordance with state and local guidance. CDC has issued guidance to provide a framework for the assessment and management of potential exposures to the virus that causes COVID-19 and implementation of safeguards based on a person's risk level and clinical presentation: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html. This guidance is updated routinely. Please see the CDC website for additional information about levels of risk.

Protective Measures that Pertain to All Work Settings

Public health departments should protect staff as they perform their work functions, and implement workplace strategies (see https://www.osha.gov/Publications/OSHA3990.pdf) that mitigate transmission of the virus that causes COVID-19. Protective measures for public health staff may vary by state and local health jurisdiction and should be guided by both state and local community transmission, the type of work that public health staff perform and the associated transmission risk, and state and local resources. Additional guidance for health departments can be found at https://www.cdc.gov/coronavirus/2019-ncov/php/index.html.

Engineering controls include:

- Use high-efficiency air filters
- Increase ventilation rates in the work environment
- Install physical barriers, such as clear plastic sneeze guards, if feasible
- In healthcare settings, such as public health clinics, use airborne infection isolation rooms for aerosol generating procedures

Administrative controls include:

- Educate workers on up-to-date information on COVID-19
- Train workers on COVID-19 risk factors and protective behaviors including:
  - Use of respiratory protection and other personal protective equipment (PPE)
  - Who needs to use protective clothing and equipment, and in which situations specific types of PPE are needed
  - How to put on, use/wear, and take PPE off correctly, especially in the context of their current and potential duties
- Encourage ill employees to stay home. Implement sick leave policies that are flexible and non-punitive.
- Provide resources and a work environment that promote personal hygiene.
  - For example, provide tissues, no-touch trash cans, hand soap, alcohol-based hand sanitizer containing at least 60 percent alcohol, disinfectants, and disposable towels for workers to clean their work surfaces; and
  - Require regular hand washing or using of alcohol-based hand sanitizer, and washing hands always when they are visibly soiled and after removing any PPE.

Protective Measures That Pertain to Public Health Clinical Settings

In **public health clinical settings**, it is important to prepare to safely triage and manage patients with respiratory illness, including COVID-19. All healthcare facilities should be aware of any updates to local and state public health recommendations.

For healthcare settings, key guidance includes:

- Minimize the numbers of staff providing care to patients with confirmed or suspected COVID-19 (see https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html),
- Implement policies to reduce face-to-face interactions by deferring non-urgent visits or use of telemedicine appointments, video or phone calls to provide treatment without a physical appointment, and referring others that require physical exam for further evaluation,
- Implement symptom screening and triage patients before they come to the clinic and provide respiratory protection (masks) to patients
- Install barriers to limit contact with patients at triage,
- Emphasize hand hygiene
- Provide appropriate PPE for staff ‘s role,
- Implement PPE optimization strategies to extend supplies (see https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).

Program managers may need to provide additional precautions while collecting specimens. Screening and symptom monitoring of staff who continue to work should also be implemented.

Published infection prevention and control guidance for preparing for and managing patients with COVID-19 in healthcare settings is available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, with specific guidance for the clinic setting available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinic-preparedness.html, and includes:

- Providing visual alerts (signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette.
- Ensuring supplies are available (tissues, waste receptacles, alcohol-based hand sanitizer).
- Making face masks available at triage for patients.
- Creating an area for spatially separating patients with respiratory symptoms, by providing space so that patients would be >6 feet apart in waiting areas. If facilities lack waiting areas, then designated areas or waiting lines should be created by partitioning or through signage.
- Reducing crowding in waiting rooms, given the highly infectious nature and gravity of COVID-19; consider asking patients waiting to be seen to stay outside and away from others or in their vehicles (if appropriate) until they are called into the facility for their appointment; alternatively, triage booths can be set up to screen patients safely.

Some facilities such as clinics, grocery stores, and banks in areas with high community transmission have found success with:

- Use of tape and signs on the ground to designate waiting areas outside and inside buildings which are 8 feet apart,
- Requiring use of face masks or other respiratory protection,
- Limiting building access to 10 people at a time, with a door monitor allowing one person inside for each person that exits,
- Providing hand sanitizer and face masks for patients upon entry into the facility for a physical appointment.

Protections that Pertain to Field-Based Public Health Staff

While existing recommendations focus primarily on healthcare settings, some public health programs have **field-based public health staff** that require protection. Staff who have close contact with patients should be equipped and trained on the use of appropriate respiratory protection and other PPE, as indicated by the current level of community transmission, and job function. For those having face-to-face interaction with patients for a disease-specific program, more comprehensive PPE may be indicated, depending upon the context, prevalence of COVID-19 in the community, degree of contact with the client, and healthcare activity pursued. For those working with persons with confirmed or suspected COVID-19 and their asymptomatic close contacts at their home or non-home residential settings, CDC has specific guidance: https://www.cdc.gov/coronavirus/2019-ncov/php/guidance-evaluating-pui.html.

For contact tracing, public health programs should consider implementing technology assisted models for client interaction such as those employed increasingly by tuberculosis programs (see https://www.cdc.gov/nchhstp/highimpactprevention/promising-hip-intervention.html), used for monitoring of returning travelers for Ebola, and implemented by sexually transmitted infection programs for partner services. Technology assisted models include those that are synchronous (such as video chat via Skype, Facetime, Webex, or Zoom, text message, and other social media) and asynchronous (such as recorded video of directly observed therapy (DOT)).

While the use of social media and smart phones is ubiquitous, not all patients have access to this technology. Patients in need of infectious disease testing and treatment services may also be persons experiencing homelessness, drug use, and mental health diagnoses. To facilitate disease prevention and control, public health programs must meet these patients where they are, providing field-based support with face-to-face interactions and in-person assistance with navigation of services. In these instances, public health staff should use appropriate PPE to prevent COVID-19 transmission. (See guidance on homelessness and COVID-19 at COVID-19 and unsheltered homelessness.) This may also include provision of face masks for patients, frequent adequate handwashing, and regular disinfection of commonly touched surfaces.

In situations where appropriate respiratory protection and other PPE are not available or community level transmission prevents face-to-face interactions, staff safety must be considered, and alternative means of contacting patients as mentioned above should be pursued.

Workplace Strategies to Mitigate Community Transmission and Maintain Continuity of Public Health Operations

Public health programs should collaborate with environmental health hospital acquired infections and occupational health programs in order to develop contingency plans to address what to do if a client comes in sick or tests positive, and what to do if an employee comes in sick or tests positive.

The possibility of pre-symptomatic or asymptomatic transmission increases the challenges of managing public health activities, underscoring the importance of prioritizing activities, use of respiratory protection and other PPE, social distancing to reduce exposure to and transmission of COVID-19, and limiting in-person care. Therefore, workers required to come to an office should wear face masks or cloth face coverings to prevent transmission.

Public health programs are encouraged to explore flexible workplace policies including telecommuting and increased sick leave. Programs should also explore telemedicine and other ways to use new technologies that may facilitate syndromic evaluation and treatment of patients.

Staff should be reminded to not report to work when they are ill. Be aware of recommended work restrictions and monitoring based on staff exposure to patients with COVID-19. Employees should be advised to check for any signs or symptoms of illness before reporting to work and to notify their supervisor if they become ill. Consider implementing a process of screening staff for fever or respiratory symptoms before entering the facility. Proactively plan for absenteeism with contingency planning that could include altering clinic hours, cross-training staff, or hiring temporary or additional employees.

Programs are encouraged to implement contingency plans to address the following: what to do if a large proportion of the workforce gets sick, what to do if staff need to provide childcare at home due to daycare or school closing, and interruptions in PPE supply.

These recommendations are aimed at assisting state, territorial, local, and tribal health departments to balance the competing demands of their routine infectious disease caseload throughout the COVID-19 response. CDC programs remain available to consult on disease-specific guidance to aid in prioritization of public health work activities.

Our thanks go out to the public health staff on the front lines who are working to balance these priorities and who rise daily to the challenge of the COVID-19 response.

Appendix: NCHHSTP Disease-Specific Recommendations

None to Minimal Transmission	Minimal to Substantial Transmission
STD priorities • Congenital syphilis cases including follow up with pregnant women and their partners • Syphilis cases who are eligible for PrEP • 3-site testing (oral, genital, anal) for MSM • CT/GC testing for adolescents • Continued STD surveillance • Timely treatment for positive cases for GC and syphilis	**STD priorities** • Congenital syphilis cases including follow up with pregnant women and their partners • Timely treatment for positive cases with titers 1≥16 or greater • Continued surveillance on congenital syphilis and high titer syphilis (1≥16) • Syphilis cases who are eligible for PrEP
TB priorities Services for clients for whom medical management cannot be delayed or interrupted: • Initial evaluation and treatment of patients with suspected or confirmed TB disease • Clinical follow-up of patients on treatment for suspected or confirmed TB disease • Directly observed therapy of patients on treatment for suspected or confirmed TB disease • Evaluation of high-risk contacts to infectious TB patients • Treatment initiation of contacts diagnosed with TB disease or latent TB infection Services for clients that could be continued or delayed depending on local circumstances: • Evaluation of low-risk contacts to infectious TB patients • Targeted TB testing • Evaluation of Class B immigrants and refugees • Administrative TB screening	**TB priorities** Services for clients for whom medical management cannot be delayed or interrupted: • Initial evaluation and treatment of patients with suspected or confirmed TB disease • Clinical follow-up of patients on treatment for suspected or confirmed TB disease • Directly observed therapy of patients on treatment for suspected or confirmed TB disease • Evaluation of high-risk contacts to infectious TB patients • Treatment initiation of contacts diagnosed with TB disease or latent TB infection
HIV priorities • Community based outreach and screening • Routine HIV testing programs • Linkage to care programs for persons newly diagnosed HIV • Return to care for persons with unsuppressed viral load • Linkage to PEP and PrEP for persons at high-risk for HIV • Maintenance of services for persons enrolled in	**HIV priorities** • Linkage to care programs for persons newly diagnosed HIV • HIV testing in clinical care settings (as deemed appropriate) • Return to care for persons with unsuppressed viral load • Linkage to PEP and PrEP for persons at high-risk for HIV • Maintenance of services for persons enrolled in

PrEP/PEP	PrEP/PEP
Hepatitis C priorities • Community based outreach and screening • Linkage to care for those diagnosed with Hepatitis C	**Hepatitis C priorities** • Linkage to care for those diagnosed with Hepatitis C

The source of the content in this document is CDC's National Center for HIV/AIDS, Viral Hepatitis, STDs, and TB Prevention.

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