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TO:	Health Alert Network
FROM:	Rachel Levine, MD, Secretary of Health
SUBJECT:	UPDATE: Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19
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This transmission is a “Health Update”, provides updated information regarding an incident or situation; unlikely to require immediate action.

HOSPITALS: PLEASE SHARE WITH ALL MEDICAL, PEDIATRIC, NURSING AND LABORATORY STAFF IN YOUR HOSPITAL; **EMS COUNCILS:** PLEASE DISTRIBUTE AS APPROPRIATE; **FQHCs:** PLEASE DISTRIBUTE AS APPROPRIATE **LOCAL HEALTH JURISDICTIONS:** PLEASE DISTRIBUTE AS APPROPRIATE; **PROFESSIONAL ORGANIZATIONS:** PLEASE DISTRIBUTE TO YOUR MEMBERSHIP; **LONG-TERM CARE FACILITIES:** PLEASE SHARE WITH ALL MEDICAL, INFECTION CONTROL, AND NURSING STAFF IN YOUR FACILITY

Updates were made to the CDC guidance for Return-to-Work Criteria for healthcare personnel (HCP) on July 17, 2020. These changes include:

- Except for rare situations, a test-based strategy is *no longer recommended* to determine when to allow HCP to return to work.
- For HCP with severe to critical illness or who are severely immunocompromised, the recommended duration for work exclusion was extended to 20 days after symptom onset (or 20 days after their initial positive SARS-CoV-2 diagnostic test for asymptomatic persons).
- Other symptom-based criteria were modified as follows:
 - Changed from “at least 72 hours” to “at least 24 hours” have passed *since last fever* without the use of fever-reducing medications
 - Changed from “improvement in respiratory symptoms” to “improvement in symptoms” to address expanding list of symptoms associated with COVID-19

The Pennsylvania Department of Health (DOH) is releasing the following guidance for making decisions about return to work for healthcare personnel (HCP) with confirmed COVID-19, or who have suspected COVID-19 (e.g., [developed symptoms of COVID-19](#) but did not get tested for COVID-19). These updates are consistent with those published by the CDC on July 17, 2020 and available for review at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>. This HAN *replaces* PA-HAN-501. If you have questions about this guidance, please contact DOH at **1-877-PA-HEALTH (1-877-724-3258)** or your local health department.

Decisions about return to work for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances. In general, a symptom-based strategy should be used as described below. The time period used to determine return to work depends on the HCP's severity of illness and if they are severely immunocompromised.¹

A test-based strategy is no longer recommended (except as noted below) 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.

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

SYMPTOM-BASED STRATEGY FOR DETERMINING WHEN HCP CAN RETURN TO WORK

HCP with [mild to moderate illness](#) who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- [Symptoms](#) (e.g., cough, shortness of breath) have improved

Note: HCP who are **not severely immunocompromised**¹ 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.

HCP with [severe to critical illness](#) or who are severely immunocompromised¹:

- At least 20 days have passed *since symptoms first appeared*
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- [Symptoms](#) (e.g., cough, shortness of breath) have improved

Note: 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.

As described in a CDC [Decision Memo](#), an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, the more conservative period of 20 days was applied in this guidance. However, because the majority of severely or critically ill patients no longer appear to be infectious 10 to 15 days after onset of symptoms, facilities operating under [critical staffing shortages](#) might choose to allow HCP to return to work after 10 to 15 days, instead of 20 days. These decisions and actions must be detailed in and consistent with the facility's emergency preparedness plan.

TEST-BASED STRATEGY FOR DETERMINING WHEN HCP CAN RETURN TO WORK

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, as described in a CDC [Decision Memo](#), 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 immunocompromised¹) 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:

HCP who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- 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 an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

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. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

RETURN TO WORK PRACTICES AND WORK RESTRICTIONS

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.
 - A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection. N95 or other respirators with an exhaust valve might *not* provide source control.
 - Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.
 - Ensure that recovered HCP wear all indicated PPE according to facility policy. The immunity of recovered persons to COVID-19 infection is not known, and a lack of proper PPE could expose HCP to other communicable diseases.

STRATEGIES TO MITIGATE HEALTHCARE PERSONNEL STAFFING SHORTAGES

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. As the COVID-19 pandemic progresses, staffing shortages might occur due to HCP exposures, illness, and need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above.

If there are no longer enough staff to provide safe patient care, and other contingency capacity strategies have been exhausted (see [CDC strategies](#)), healthcare facilities and employers may need to implement crisis capacity strategies to continue to provide patient care. The decision to follow contingency or crisis standards belongs to the healthcare facility, but these decisions and actions must be detailed in and consistent with their emergency preparedness plan.

Under **crisis capacity strategies**, HCP who have recovered from COVID-19, and are well enough to work, are permitted to return to work before meeting above criteria. Such HCP should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:

1. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
2. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
3. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
4. As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients *without* suspected or confirmed COVID-19.

If HCP are permitted to return to work before meeting all return to work criteria, they should still adhere to all Return to Work Practices and Work Restrictions recommendations described above. Feeling well enough to work is a decision that can only be made by the healthcare worker, understanding that their regular duties are likely to be physically demanding. If agreeable to all parties, consider shortened shifts or extra breaks for HCP who feel well enough to work, but have not fully recovered from illness.

Refer to the [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#) document for more information.

DEFINITIONS

Cloth face covering: Textile (cloth) covers are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE and it is uncertain whether cloth face coverings protect the wearer.** CDC has guidance available on [design, use, and maintenance of cloth face coverings](#).

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Healthcare Personnel (HCP): HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

SARS-CoV-2 Illness Severity Criteria (adapted from the [NIH COVID-19 Treatment Guidelines](#)):

Note: The studies used to inform this guidance did not clearly define “severe” or “critical” illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about when HCP with SARS-CoV-2 infection may return to work, the definitions in the [National Institutes of Health \(NIH\) COVID-19 Treatment Guidelines](#) are one option for defining severity of illness categories. The highest level of illness severity experienced by the HCP at any point in their clinical course should be used when determining when they may return to work.

Mild Illness: Individuals who have any of the various [signs and symptoms of COVID 19](#) (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO₂) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO₂ <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO₂/FiO₂) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

FOOTNOTES

1. The studies used to inform this guidance did not clearly define “severely immunocompromised”. For the purposes of this guidance, CDC used the following definition that was created to more generally address HCP occupational exposures.
 - Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and require actions such as lengthening the duration of HCP work restrictions.
 - Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect occupational health actions to prevent disease transmission.
 - Ultimately, the degree of immunocompromise for HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Categories of Health Alert messages:

Health Alert: conveys the highest level of importance; warrants immediate action or attention.

Health Advisory: provides important information for a specific incident or situation; may not require immediate action.

Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

This information is current as of Jul 18, 2020 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.