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<b>TO:</b>	Health Alert Network
<b>FROM:</b>	Keara Klinepeter, Acting Secretary of Health
<b>SUBJECT:</b>	<b>UPDATE: Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19</b>
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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

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, this guidance is being updated to enhance protection for healthcare personnel (HCP), patients, and visitors, and to address concerns about potential impacts on the healthcare system given a surge of SARS-CoV-2 infections. These updates will be refined as additional information becomes available to inform recommended actions. Updates include:

- Antigen testing is preferred if testing symptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days. If tests are in short supply, they should be prioritized to diagnose infection.
- Added additional information to strategies to mitigate healthcare personnel staffing shortages.

If you have additional questions about this guidance or would benefit from discussion to support infection prevention and control decisions in your facility, please contact DOH at **1-877-PA- HEALTH (1-877-724- 3258)** or your local health department.

The Pennsylvania Department of Health (DOH) is releasing the updated 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 January 21, 2022 and available for review at [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#). This HAN *replaces* PA-HAN-614. If you have questions about this guidance, please contact DOH at **1-877-PA-HEALTH (1-877-724-3258)** or your local health department.

## Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 Infection

HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with approved nucleic acid or antigen detection assays regardless of vaccination status; ensure that SARS-CoV-2 testing is performed with a test that is capable of detecting SARS-CoV-2 even with currently circulating variants in the United States. When a clinician decides that testing a person for SARS-CoV-2 is indicated, negative results from at least one FDA Emergency Use Authorized [COVID-19 viral test](#) indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 RNA may be performed at the discretion of the evaluating clinician, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists.

For HCP who were suspected of having COVID-19 but following evaluation another diagnosis is suspected or confirmed, return to work decisions should be based on their other suspected or confirmed diagnoses.

### RETURN TO WORK CRITERIA FOR HCP WITH SARS-CoV-2 INFECTION

The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work regardless of vaccination status (boosted, vaccinated, or unvaccinated). After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.

Either an antigen test or nucleic acid amplification test (NAAT) can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. **Antigen testing is preferred if testing symptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days. If tests are in short supply, testing should be prioritized to diagnose infection.**

*HCP with mild to moderate illness who are not moderately to severely immunocompromised:*

- HCP can return to work if at least 7 days have passed since symptoms first appeared AND a negative antigen or NAAT is obtained within 48 hours prior to returning to work OR 10 days have passed if testing is not performed or the HCP tests positive at day 5-7, **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.

*HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised:*

- HCP can return to work if at least 7 days have passed since the date of their first positive viral test AND a negative antigen or NAAT is obtained within 48 hours prior to returning to work OR 10 days have passed if testing is not performed or the HCP tests positive at day 5-7.

*HCP with severe to critical illness and are **not** moderately to severely immunocompromised:*

- **At least 10 days and up to 20 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.
- **For HCP with severe to critical illness**, the test-based strategy as described for moderately to severely immunocompromised HCP below can be used to inform the duration of isolation.

The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to [Ending Isolation and Precautions for People with COVID-19: Interim Guidance](#).

HCP who are [moderately to severely immunocompromised](#) may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.
- 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  $\geq 24$  hours apart (total of two negative specimens) tested using an antigen test or NAAT.
  - *HCP who are not symptomatic:*
    - Results are negative from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens) tested using an antigen test or NAAT.

## RETURN TO WORK PRACTICES

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. After this 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.
  - 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.

Mitigation strategies offer a continuum of options for addressing staffing shortages. Contingency capacity strategies, followed by crisis capacity strategies, augment conventional strategies and are meant to be considered and implemented sequentially (i.e., implementing contingency strategies before crisis strategies). Under **contingency** and **crisis capacity strategies**, HCP who are well enough to work are permitted to return to work before meeting above criteria. **See Table 1 for a summary of the strategies.** Such HCP should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology).

Allowing HCP with SARS-CoV-2 infection or higher-risk exposures to return to work before meeting the conventional criteria could result in healthcare-associated SARS-CoV-2 transmission. Healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is utilizing these strategies, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill staffing needs.

**At baseline, healthcare facilities must:**

- Ensure any COVID-19 vaccine requirements for HCP are followed, and where none are applicable, encourage HCP to remain [up to date](#) with all recommended COVID-19 vaccine doses.
- Understand their normal staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care under normal circumstances.
- Understand the local epidemiology of COVID-19-related indicators (e.g., community transmission levels).
- Communicate with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed.

If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, if they are well enough and willing to work, even if they have not met all conventional return-to-work criteria.

Considerations for determining which HCP should be prioritized for this option include:

- The type of HCP shortages that need to be addressed.
- Where individual HCP are in the course of their illness (e.g., viral shedding is likely to be higher earlier in the course of illness).
- The types of symptoms they are experiencing (e.g., persistent fever, cough).
- Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
- The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than patients who are immunocompromised).

If HCP are permitted to return to work before meeting all conventional return-to-work criteria, they should still adhere to the recommendations described below. 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.

- They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
- Until they meet the conventional return to work criteria:
  - They should wear a respirator or well-fitting facemask at all times, even when they are in non-patient care areas such as breakrooms.
    - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
  - To the extent possible, they should practice physical distancing from others.
  - Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.

### **Contingency Capacity Strategies to Mitigate Staffing Shortages**

Allowing HCP with SARS-CoV-2 infection who are well enough and willing to work to return to work as follows:

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

- At least 5 days have passed since symptoms first appeared (day 0), **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.

Healthcare facilities may choose to confirm resolution of infection with a negative antigen test or NAAT\*.

*HCP who were asymptomatic throughout their infection and are not [moderately to severely immunocompromised](#):*

- At least 5 days have passed since the date of their first positive viral test (day 0)

Healthcare facilities may choose to confirm resolution of infection with a negative antigen test or NAAT\*.

\*Either an antigen test or NAAT can be used when referenced in the criteria above. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

### **Crisis Capacity Strategies to Mitigate Staffing Shortages**

If HCP are requested to work before meeting all criteria, they should be restricted from contact with patients who are moderately to severely immunocompromised (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:

- If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
- Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.
- Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with suspected SARS-CoV-2 infection.
- As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients *without* suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies that do not involve care of uninfected patients by potentially infectious HCP. Strict adherence to all other recommended infection prevention and control measures (e.g., [use of respirator or well-fitting facemask for source control](#)) is essential.

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

**Table 1. Summary of Strategies for Mitigating Staffing Shortages for HCP with SARS-COV-2 Infection**

Vaccination Status	Conventional	Contingency	Crisis
Up to Date, Unvaccinated, and <u>Not Up to Date</u>	10 days OR 7 days with negative test <sup>†</sup> , if asymptomatic or mild to moderate illness (with improving symptoms)	5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)	No work restrictions, with prioritization considerations (e.g., types of patients they care for)

<sup>†</sup>Negative test result from test collected within 48 hours of returning to work. For calculating the day of the test, consider day of symptom onset (or first positive test if asymptomatic) as day 0.

## 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](#) and [how to improve mask fit](#).

**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.

**Fever:** For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0°F (37.8°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs]).

**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.

### **Immunocompromised**

For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the CDC Interim [Clinical Considerations for Use of COVID-19 Vaccines](#).

- Other factors, such as end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about need for work restriction if the healthcare provider had close contact with someone with SARS-CoV-2 infection. However, people in this category should still consider continuing to practice physical distancing and use of source control while in a healthcare facility, even if they have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC.
- Ultimately, the degree of immunocompromise for HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

**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 (SpO<sub>2</sub>) ≥94% on room air at sea level.

**Severe Illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO<sub>2</sub> <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 (PaO<sub>2</sub>/FiO<sub>2</sub>) <300 mmHg, or lung infiltrates >50%.

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

**Up to date:** In general, being up to date on COVID-19 vaccination includes receiving all vaccines according to the recommendations provided by CDC. This includes a primary series of vaccine, booster doses, and any recommended third doses for immunocompromised people. For specifics, refer to [CDC guidance](#).

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 January 25, 2022 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.