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

Who this is for:

Occupational health programs and public health officials 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 a respiratory infection [e.g., cough, sore throat, shortness of breath, fever] but did not get tested for COVID-19).

Decisions about return to work for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or time-based strategy or a test-based strategy. Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

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

Symptomatic HCP with suspected or confirmed COVID-19 (Either strategy is acceptable depending on local circumstances):

- Symptom-based strategy. 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 respiratory 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 (Either strategy is acceptable depending on local circumstances):

- Time-based strategy. 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 respiratory 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.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Consider consulting with local infectious disease experts when making decisions about discontinuing Transmission-Based Precautions for individuals who might remain infectious longer than 10 days (e.g., severely immunocompromised).

If HCP had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Always wear a facemask for source control 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 higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
    - Of note, 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

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 will likely occur due to HCP exposures, illness, or 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. 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 in 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.

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.

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.

For the most up to date CDC guidance see Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19.

Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings

Who this is for:

Healthcare providers and public health officials managing persons with coronavirus disease 2019 (COVID-19) under isolation who are not in healthcare settings. This includes, but is not limited to, at home, in a hotel or dormitory room, or in a group isolation facility.

For Persons with COVID-19 Under Isolation:

The decision to discontinue home isolation for persons with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or a test-based strategy. Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

1). Symptom-based strategy

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

- 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.

2). Test-based strategy Previous recommendations for a test-based strategy remain applicable; however, a test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing.

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

- 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 respiratory 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.

For Persons Who have NOT had COVID-19 Symptoms but Tested Positive and are Under Isolation:

Options now include both a 1) time-based strategy, and 2) test-based strategy.

1). Time-based strategy

Persons with laboratory-confirmed COVID-19 who have not had any symptoms and were directed to care for themselves at home may discontinue isolation under the following conditions:

- At least 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.

2). Test-based strategy

Persons with laboratory-confirmed COVID-19 who have not had any symptoms and were directed to care for themselves at home may discontinue isolation under the following conditions:

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory 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.

The symptom-based, time-based, and test-based strategies may result in different timeframes for discontinuation of isolation post-recovery. For all scenarios outlined above, the decision to discontinue isolation should be made in the context of local circumstances.

Note that recommendations for discontinuing isolation in persons known to be infected with COVID-19 could, in some circumstances, appear to conflict with recommendations on when to discontinue quarantine for persons known to have been exposed to COVID-19. CDC recommends 14 days of quarantine after exposure based on the time it takes to develop illness if infected. Thus, it is possible that a person known to be infected could leave isolation earlier than a person who is quarantined because of the possibility they are infected.

This recommendation will prevent most, but cannot prevent all, instances of secondary spread. The risk of transmission after recovery is likely substantially less than that during illness; recovered persons will not be shedding large amounts of virus by this point, if they are shedding at all. Employers and local public health authorities can choose to apply more stringent criteria for certain persons where a higher threshold to prevent transmission is warranted.

For certain populations, a longer timeframe after recovery may be desired to minimize the chance of prolonged shedding of replication-competent virus. Such persons include 1) healthcare personnel in close contact with vulnerable persons at high-risk for illness and death if those persons get COVID-19 and 2) persons who have conditions that might weaken their immune system which could prolong viral shedding after recovery. Such persons should consult with their healthcare provider; this might include additional PCR testing. Prolonged viral shedding has been demonstrated without direct correlation with replication competent virus.

For the most up to date CDC guidance see Discontinuation of Isolation for Persons with COVID -19 Not in Healthcare Settings.

Laboratory Testing FAQs

What is Reverse-Transcriptase Polymerase Chain Reaction (RT-PCR)?

PCR is a very common scientific technique that has been widely used in both research and medicine to detect genetic information. RT-PCR is a special version used when RNA is being detected. It is being used to detect SARS-CoV-2, the virus causing COVID-19. RT-PCR tests for the presence of the virus RNA. This test is quick, sensitive and reliable.

When should the RT-PCR test be used?

The RT-PCR test is diagnostic and should be used to determine an active infection of COVID-19. Patients that present with symptoms of COVID-19 should have an RT-PCR test performed. This test can only determine if the patient is currently infected at the time of specimen collection, not if they previously had the disease.

RT-PCR performed on a nasopharyngeal swab is the current gold standard for diagnosis of an active COVID infection. Though it is possible that either a throat or nasal swab will be taken for RT-PCR, as these types of specimens have been shown to be of nearly equal quality to nasopharyngeal swabs.

What is needed for specimen collection?

CDC recommends collecting and testing an upper respiratory specimen. The following are acceptable specimens:

- A nasopharyngeal (NP) specimen collected by a healthcare professional; or
- An oropharyngeal (OP) specimen collected by a healthcare professional; or
- A nasal mid-turbinate swab collected by a healthcare professional or by a supervised onsite self-collection (using a flocked tapered swab); or
- An anterior nares (nasal swab) specimen collected by a healthcare professional or by onsite or home self-collection (using a flocked or spun polyester swab); or
- Nasopharyngeal wash/aspirate or nasal wash/aspirate (NW) specimen collected by a healthcare professional.

How should the specimen be handled and transported?

- Specimen is stable for 72 hours at 2-8°C degrees. Long storage times are allowable but will require that the specimen be frozen.
- Specimen must be kept at 2-8°C (refrigerated/cool) or frozen

What is antibody testing?

An antibody test looks for the presence of antibodies, which are specific proteins made in response to infections. Antibodies can be found in the blood of people who are tested after infection and show that people have had an immune response to the infection. Antibody test results are especially valuable for detecting previous infections with few or no symptoms.

However, we do not know if the antibodies that result from SARS-CoV-2 infection will provide someone with immunity from a future infection. If antibodies do provide immunity, we don't know what titer or amount of antibodies would be protective or the duration that protection would last.

When should antibody testing be used?

Antibody testing should **not** be used as the sole basis to diagnose COVID-19. It typically takes 1 to 3 weeks after someone becomes infected with SARS-CoV-2 for their body to make antibodies; some people may take longer to develop antibodies. Depending on when someone was infected and the timing of the test, the test may not find antibodies in someone with an active infection.

Antibody testing is a mechanism to assess previous infection with COVID-19. This testing is important to better understand the level of antibodies needed for protection, the duration of that protection, and the factors associated with whether a person develops a protective antibody response.

Antibody testing is designed and validated to be used for broad-based surveillance and research purposes, to provide information needed to guide the response to the pandemic and protect the public's health. This test is not currently designed for individual use, i.e., to test people who want to know if they have been previously infected with SARS-CoV-2

What is needed for specimen collection?

Specimen Type: Blood Plasma or serum

Blood Collection Tube Type: Mint-top tube (lithium heparin, gel or no-gel tube)

Required Volume (adult): 2 mL plasma

Minimum Volume (pediatric): 1 mL plasma

How should the specimen be handled?

Plasma must be centrifuged within 6 hours of collection. Specimen is stable at 2-8°C for up to 3 days.

If sending whole blood, refrigerated (2-8°C) samples must be received within 2 hours of collection.