

PENNSYLVANIA DEPARTMENT OF HEALTH
2021 – PAHAN – 595 – 09-16-UPD
UPDATE: Return to Work for Healthcare
Personnel with Confirmed or Suspected COVID-19

This document has been archived.
 Please refer to [PA-HAN-614](#) for
 updated information on the topic.



DATE:	9/16/21
TO:	Health Alert Network
FROM:	Alison Beam, JD, Acting Secretary of Health
SUBJECT:	UPDATE: Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19
DISTRIBUTION:	Statewide
LOCATION:	n/a
STREET ADDRESS:	n/a
COUNTY:	n/a
MUNICIPALITY:	n/a
ZIP CODE:	n/a

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

Minor updates were made to the CDC guidance for Return-to-Work Criteria for healthcare personnel (HCP) on September 10, 2021. These updates include:

- The definition of immunocompromised has changed based on evolving science, and now refers to the CDC guidance.
- When using a symptom-based strategy to determine when HCP with severe to critical illness or who are moderately to severely immunocompromised can return to work, the language has changed to rely more on clinical judgement. In brief, HCP in this category can return to work when at least 10 days and up to 20 days have passed *since symptoms first appeared*.

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 September 10, 2021 and available for review at [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC](#). This HAN *replaces* PA-HAN-553. 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 that individual is moderately to severely immunocompromised.

A test-based strategy is not 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

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. 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.

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

A symptom-based strategy for determining when HCP with SARS-CoV-2 infection could return to work is preferred in most clinical situations.

The criteria for the symptom-based strategy are:

HCP with mild to moderate illness who are not moderately to 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.

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

- 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 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.
 - Consider consultation with infectious diseases and infection prevention and control specialists.

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. For these HCP:

- Consultation with infectious diseases and infection prevention and control specialists is recommended.
- Consider use of a test-based strategy in consultation with occupational health for determining when these HCP may return to work.

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

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 example, HCP with characteristics of severe illness may be most appropriately managed by staying home for at least 15 days before return to work. Use of a test-based strategy, in consultation with infectious disease specialists and occupational health, for determining when HCP who are severely immunocompromised may return to work could be considered. [Limitations of the test-based strategy](#) are described elsewhere.

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. 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.

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.

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](#) 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, fully vaccinated people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility, even when not otherwise recommended for fully vaccinated individuals.
- 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 (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.

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 September 16, 2021 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.
--