PENNSYLVANIA DEPARTMENT OF HEALTH

2022 – PAHAN – 661 – 9-30- UPD

UPDATE: Work Restrictions for Healthcare Personnel with Exposure to COVID-19

DATE:	9/30/2022
TO:	Health Alert Network
FROM:	Denise Johnson, Acting Secretary of Health
SUBJECT:	**UPDATE: Work Restrictions for Healthcare Personnel with Exposure to 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

This guidance replaces PA-HAN-621 and includes changes made by CDC on September 23, 2022.

This guidance pertains only to the healthcare personnel and their need for work restriction. For guidance on isolation and quarantine in the community, please refer to PA-HAN-619 or its successor.

Major additions and edits in this version include:

- Revised work restriction guidance. In most circumstances, asymptomatic HCP with higher-risk exposures **do not** require work restriction. However, they should receive a series of three viral tests on day 1, day 3, and day 5 after the exposure (day 0). Additionally, they should wear well-fitting source control and monitor for signs and symptoms of COVID-19 for 10 days.
- Updated recommendations for testing frequency to detect potential for variants with shorter incubation periods and to address the risk for false negative antigen tests in people without symptoms.
- Removed contingency and crisis strategies about earlier return to work for HCP with higher-risk exposures.

If you have additional questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877-724-3258) or your local health department.

This guidance replaces PA-HAN-621 and includes the following sections:

1. Background
2. Definition of a higher-risk exposure for HCP
    a. Community-related exposure
    b. Household exposure
    c. Exposure in the healthcare setting while at work
3. Return to work criteria for HCP who were exposed to individuals with confirmed COVID-19

1. BACKGROUND

Because of their often extensive and close contact with vulnerable individuals in healthcare settings, a conservative approach to managing HCP with higher-risk exposure is recommended to prevent transmission from potentially contagious HCP to patients and residents, other HCP, and visitors. Occupational health programs should have a low threshold for evaluating any potential symptoms of COVID-19 and testing HCP.

This guidance describes the process for contact tracing and application of testing and work restrictions (if applicable) that should occur when capacity exists to perform these activities without compromising other critical infection prevention and control functions. If a healthcare facility is not performing contact tracing, testing, and work restrictions (if applicable) as outlined in this guidance, they must be operating according to the facility's emergency management plan.

This guidance is based on currently available data about COVID-19. Occupational health programs should use clinical judgement as well as the principles outlined in this guidance to assign risk level and determine the need for work restrictions.

2. DEFINITION OF A HIGHER-RISK EXPOSURE FOR HCP

The term **higher-risk exposure** has been used by CDC and the Department of Health to outline when work restriction might occur for HCP following exposure to COVID-19. **A higher-risk exposure includes any exposure to COVID-19 that meets the criteria outlined below for community-related exposure, for household exposure, or for higher-risk exposure in the healthcare setting while at work.**

a. Community-related exposure

As outlined in the CDC guidance for community-related exposure to COVID-19, persons who have had close contact (within 6 feet for a total of 15 minutes or more) with an infectious person with COVID-19 are considered exposed. Other activities of shorter duration may also be considered close contact, like providing care for a sick person, hugging, or kissing them, sharing dishware or utensils, and having been coughed or sneezed upon by an infectious person.

Note that when an HCP is exposed to COVID-19 within a healthcare setting as a *patient or visitor*, the criteria for community-related exposure apply.

b. Household exposure

An infectious person living in the home with an HCP represents an exposure to that HCP except in the unusual situation that the HCP was not in the home at any point during the infectious period (for example, HCP had been away on vacation or staying elsewhere). In most cases, the shared environment represents a level of risk consistent with higher-risk exposure, even if two persons in the home are not in direct contact with each other (e.g., as reported sometimes by roommates who work different shifts).

For HCP who share a household with someone who has COVID-19, the HCP's testing and work restriction period (if applicable) start from the last time they were exposed to the person with COVID-19. If the person with COVID-19 cannot fully isolate and exposure is ongoing, the HCP should extend their testing and work restriction. In that case, the day the person with COVID-19 is released from isolation would be day 0 for exposure.

c. Exposure in the healthcare setting while at work

Higher-risk exposures in the healthcare setting generally involve exposure of HCP eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure. Other exposures classified as lower-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth.

When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission.

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection[3] and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask);[4]
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask; or
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure.

3. RETURN TO WORK CRITERIA FOR HCP WHO WHERE EXPOSED TO INDIVIDUALS WITH CONFIRMED COVID-19

In most circumstances, asymptomatic HCP with higher-risk exposures do not require work restriction. Examples of when work restriction may be considered are described below.

Following a higher-risk exposure HCP should:

- Have a series of three viral tests for SARS-CoV-2 infection.
    - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
    - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Wear well-fitting source control for 10 days following the exposure.
- Monitor themselves for fever or symptoms consistent with COVID-19, and not report to work when ill or if testing positive for SARS-CoV-2 infection.
    - Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
- Follow additional recommended infection prevention and control practices as outlined by facility policy.

In addition to testing, source control, and monitoring recommendations listed above, examples of when work restriction may be considered for asymptomatic HCP following a higher-risk exposure include:

- HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure;
- HCP is moderately to severely immunocompromised;
- HCP cares for or works on a unit with patients who are moderately to severely immunocompromised;
- HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

If work restriction is recommended, HCP could return to work after either of the following time periods:

- HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing (at least three tests as described above) for HCP following a higher-risk exposure is negative.
- If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

Footnotes:

1. For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, **any duration** should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.
2. For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.
3. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious:
    a. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions
    b. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.
        i. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with SARS-CoV-2 infection, facemasks still confer some level of protection to HCP, which was factored into this risk assessment if the patient was also wearing a cloth mask or facemask

Definitions:

Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. **They are not personal protective equipment (PPE) appropriate for use by healthcare personnel.** Guidance on design, use, and maintenance of cloth masks is available.

Facemask: OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as ‘medical procedure masks’.” Facemasks should be used 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. Other facemasks, 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.

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 are up to date with vaccine as recommended by CDC.
- Ultimately, the degree of immunocompromise for the healthcare provider 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, including those intended for use in healthcare, are certified by the CDC/NIOSH.

If you have questions about this guidance, please contact DOH at 1-877-PA-HEALTH (1-877- 724-3258) or your local health department.

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 30, 2022 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.