PENNSYLVANIA DEPARTMENT OF HEALTH
2022 – PAHAN – 662– 9-30-UPD
UPDATE: Return to Work for Healthcare Personnel with
Confirmed or Suspected COVID-19

DATE:	9/30/2022
TO:	Health Alert Network
FROM:	Denise Johnson, Acting Secretary of Health
SUBJECT:	**UPDATE: Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19**
DISTRIBUTION:	Statewide
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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

This guidance replaces PA-HAN-622 and includes changes made by CDC on September 23, 2022. Major additions and edits in this version include:

Requirements for testing healthcare personnel (HCP) with symptoms of COVID-19 have been updated. In summary:
- If using NAAT (molecular), a single negative test is sufficient in most circumstances.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

The section on Strategies to Mitigate Healthcare Personnel Staffing Shortages has been condensed, with the expectation that facilities will refer to the CDC guidance for additional details.

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

1. **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.

When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected.
- If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT.
- If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test.

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.

2. **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) and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

HCP with [mild to moderate illness](#) who are not [moderately to severely immunocompromised](#):
- Can return to work if at least 7 days have passed *since symptoms first appeared* AND a negative antigen* or NAAT (molecular) 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.

* If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

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

- 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 (molecular) 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.

  * If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

*HCP with severe to critical illness and are **not** moderately to severely immunocompromised:*
- Can return to work if 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 ≥ 48 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 ≥ 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

3. 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.

4. 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. If community transmission levels rise, staffing shortages could occur due to HCP illness or the 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 these shortages. These plans and processes include communicating with HCP about actions the facility is taking to address shortages, maintaining patient and HCP safety, and providing resources to assist HCP with anxiety and stress.

If there are no longer enough staff to provide safe patient care, facilities should consider implementing CDC's Strategies to Mitigate Healthcare Personnel Staffing Shortages. Facility policy should include details provided in the CDC guidance; a summary is provided in Table 1 below. 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).

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

Conventional	Contingency	Crisis
10 days OR 7 days with negative test[†], 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)

[†]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. Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

[§]Healthcare facilities may choose to confirm resolution of infection with a negative NAAT (molecular) or a series of 2 negative antigen tests taken 48 hours apart.

DEFINITIONS

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.

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, including those intended for use in healthcare, are certified by the CDC/NIOSH.

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