

Return to Work Guidance After COVID-19 Illness or Exposure for Persons Who Are Not Healthcare Personnel

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If assessing healthcare personnel, please review DPH Healthcare Worker Return to Work Guidance <https://dph.georgia.gov/document/document/dph-return-work-guidance/download>

The following guidance should be used to make decisions about “return to work” for persons who **are not Healthcare Personnel**:

- with laboratory-confirmed COVID-19;
- who have suspected COVID-19 (e.g., developed symptoms of a respiratory infection [e.g., cough, shortness of breath, fever] but did not get tested for COVID-19 and have been exposed to a person with COVID-19 or live in an area with local or widespread transmission;
- who have been exposed to COVID-19 without appropriate personal protective equipment (PPE).

Return to Work Strategy

DPH recommends a time-based return to work strategy that is determined based on a person’s health status. Decisions about “return to work” for persons with confirmed or suspected COVID-19 who are not healthcare personnel should be made in the context of local circumstances (community transmission, resource needs, etc.).

Symptomatic persons who are not healthcare personnel with confirmed COVID-19 or suspected COVID-19

- Who had *mild or moderate illness* and are not severely immunocompromised[†]* can return to work after:
 - 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
- Who had *severe to critical illness (if they were hospitalized for shortness of breath, pneumonia, low oxygen levels, respiratory failure, septic shock, and/or multiple organ failure) * or who are severely immunocompromised[†]* can return to work after:
 - At least 20 days have passed *since symptoms first appeared*
 - 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

Asymptomatic persons who are not healthcare personnel with confirmed COVID-19:

- Who are *not severely immunocompromised[†]* can return to work after:
 - At least 10 days have passed since the positive laboratory test and the person remains asymptomatic
- Who are *severely immunocompromised[†]* can return to work after:

- At least 20 days have passed since the positive laboratory test and the person remains asymptomatic
- Note, asymptomatic persons who test positive and later develop symptoms should follow the guidance for symptomatic persons above.

Asymptomatic persons who are not healthcare personnel, and who do not work in critical infrastructure who have a known exposure to a person with COVID-19 without appropriate PPE can return to work after:

- After they have completed all requirements in the DPH guidance for persons exposed to COVID-19 found at <https://dph.georgia.gov/contact>
- Of note, if this person is tested for COVID-19 during the 14-day quarantine period, a negative test result would not change or decrease the time a person is monitored.

Asymptomatic persons who are not healthcare personnel, but who do work in critical infrastructure who have a known exposure to a person with COVID-19 can follow the CDC guidance for return to work:

- <https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html>

Both CDC and DPH **DO NOT** recommend using a test-based strategy for returning to work (2 negative tests at least 24 hours apart) after COVID-19 infection for non-healthcare personnel. ‡ CDC has reported prolonged PCR positive test results without evidence of infectiousness. In one study, individuals were reported to have positive COVID-19 tests for up to 12 weeks post initial positive.

More information about the science behind the symptom-based return to work can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html>

Return to Work Practices and Work Restrictions

Persons who are not healthcare personnel who complete the above conditions and can return to work should:

- Wear a face covering if social distancing cannot be maintained in the workplace, per current CDC guidelines: <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover.html>. Note: A facemask, instead of a cloth face covering, should be used by healthcare providers only. Cloth face coverings are appropriate for persons who are not healthcare personnel and are recommended by CDC to help prevent asymptomatic spread of COVID-19 in settings where social distancing cannot be practiced.
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in [CDC's interim infection control guidance](#) (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.

CDC guidance for discontinuation of home isolation for persons with COVID-19 infection not in a healthcare setting can be used in conjunction with this guidance for returning to work and can be found at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html>

** 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 duration of Transmission-Based Precautions, 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 patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions.*

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) \geq 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.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

† The studies used to inform this guidance did not clearly define “severely immunocompromised.” For the purposes of this guidance, CDC used the following definition:

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200 , combined primary immunodeficiency disorder, and receipt of prednisone >20 mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.*
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.*
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.*

*‡ Completing a test-based strategy is contingent upon the availability of ample testing supplies, laboratory capacity, and convenient access to testing and requires two samples taken at least 24 hours apart. If a facility requires the test-based strategy for return (**which is discouraged by DPH**), this should be done by a private physician through a commercial lab. The test-based strategy is not fulfilled by a single test, nor should it be used for screening of all persons returning to work.*