

## Healthcare Personnel Return to Work Guidance After COVID-19 Illness or Exposure

July 22, 2020

The following guidance should be used to make decisions about “return to work” for healthcare personnel (HCP):

- 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).

Decisions about “return to work” for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances (community transmission, resource needs, etc.). Return to work recommendations are determined based on the status of the HCP (below).

### Symptomatic healthcare personnel with confirmed COVID-19 or suspected COVID-19

- Who had *mild or moderate illness\* and are not severely immunocompromised<sup>†</sup>* 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<sup>†</sup>* 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 healthcare personnel with confirmed COVID-19:

- Who are *not severely immunocompromised<sup>†</sup>* 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<sup>†</sup>* 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 HCPs who were exposed 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, but a positive test would move the person into one of the above categories, based on whether they are still asymptomatic or have developed symptoms.
- Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after all options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities should have the exposed HCP wear a facemask while at work for the 14 days after the exposure event. If HCP develops even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing) and leave work (after notifying their supervisor or occupational health services).

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.<sup>‡</sup> 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 strategy for discontinuing isolation can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html>

Consider consulting with public health or local infectious disease experts when making return to work decisions for individuals who might remain infectious longer than 10 days (e.g., severely immunocompromised).

Return to Work Practices and Work Restrictions

HCP who complete the above conditions and can return to work should:

- Wear a facemask at all times while in the healthcare facility until
  - all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
  - 14 days after a positive COVID-19 test in an asymptomatic HCP
  - All quarantine guidance has been completed for close contacts of persons with COVID-19 <https://dph.georgia.gov/contact>
  - Note: A facemask instead of a cloth face covering should be used by these HCP during this time period. After this time period, these HCP should revert to their facility policy regarding PPE.
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset (or positive COVID-19 test in an asymptomatic HCP)
- 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

### Crisis Strategies to Mitigate Staffing Shortages

Healthcare systems, healthcare facilities, and health authorities might determine that the recommended approaches cannot be followed due to the need to mitigate HCP staffing shortages. In such scenarios:

- HCP should be evaluated by the facilities' occupational health staff to determine appropriateness of earlier return to work than recommended above
- If HCP return to work earlier than recommended above, they should still adhere to the Return to Work Practices and Work Restrictions recommendations above. For more information, see [CDC Strategies to Mitigate Healthcare Personnel Staffing Shortages](#).

For current CDC HCP return to work guidance see: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html>

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*\* 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 (SpO<sub>2</sub>) ≥94% on room air at sea level.*

*Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO<sub>2</sub> <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 (PaO<sub>2</sub>/FiO<sub>2</sub>) <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 >20mg/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.*