

## Criteria for [Return to Work](#) and Crisis Staffing in Long Term Care Facilities and Other Health Care Settings December 16, 2020

The following guidance is for long-term care facilities (LTCF) and other health care settings to manage healthcare personnel (HCP) on quarantine (HCP with an unprotected exposure to COVID-19) and isolation (HCP with SARS-CoV-2 infection).

### Return to Work Criteria for HCP on Quarantine

HCP with an [unprotected exposure](#) to COVID-19 should:

- Be excluded from work and quarantine for [at least 10](#) days after last exposure.
- HCP that return to work after 10 days of quarantine must still monitor themselves daily for symptoms of COVID-19 and strictly adhere to all COVID-19 mitigation measures (social distancing, avoiding gatherings, face mask use, etc.) for a full 14 days after last potential exposure.

While NH DPHS has decreased the required quarantine period for people potentially exposed to COVID-19 from 14 to 10 days, which is consistent with new [CDC quarantine guidance](#), DPHS recommends that organizations and HCP serving vulnerable populations or congregate living settings that are high-risk for transmission (e.g., long-term care facilities, jails/prisons, etc.) maintain a 14 day quarantine\* for residents and staff to minimize risk of transmission in their facilities.

If staffing shortage has resulted because employees are out on quarantine and the facility cannot maintain operations, the following options can be applied:

- A negative PCR test result from a specimen collected on days 6-7 or later of quarantine can allow the HCP to end quarantine after day 7 if the person remains asymptomatic.
  - Because COVID-19 can still develop for up to 14 days after an exposure, any HCP ending quarantine early must still self-monitor daily for symptoms of COVID-19 and strictly adhere to all COVID-19 mitigation measures (social distancing, avoiding gatherings, face mask use, etc.) for a full 14 days after last potential exposure.
- See "[Mitigating Staff Shortages](#)" below for allowing essential personnel to return to work sooner after an unprotected exposure.

\*The incubation period for SARS-CoV-2 ranges from 2-14 days, so a person exposed to the SARS-CoV-2 virus can develop illness up to 14 days after exposure, although the risk of spreading disease between days 10-14 after an exposure is small, especially if social distancing and face mask use recommendations are strictly followed. Early release from quarantine, however, does incur a small risk of missing individuals who develop illness late in the incubation period.

### Return to Work Criteria for HCP on Isolation with SARS-CoV-2 Infection

DPHS recommends the symptom-based strategy over the test-based strategy to allow HCP to return to work. However, in some instances, a test-based strategy could be considered if shorter than the symptom-based strategy and is

preferred for some HCP (e.g., those who are severely immunocompromised<sup>i</sup>) in consultation with local infectious diseases experts.

**Symptom based strategy for determining when HCP can [return to work](#):**

- For HCP with mild to moderate illness<sup>ii</sup> who are not 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
  - *Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.*
- For HCP with severe to critical illness<sup>iii</sup> or who are 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
  - *Note: HCP who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when **at least 10 days and up to 20 days** have passed since the date of their first positive viral diagnostic test.*

**Test-based strategy for determining when HCP can [return to work](#):**

- *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  $\geq 24$  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 asymptomatic:*
  - Results are negative from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

Regardless of symptoms, all HCP with confirmed COVID-19 must adhere to the following after returning to work:

- Wear a facemask (rather than a cloth face covering) for [source control](#) (i.e., to protect those around the wearer) at all times while in the healthcare facility;
  - Wear an N95 or higher-level respirator (and other recommended PPE) for aerosol-generating procedures when caring for patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might **NOT** provide source control.
- Do not care for severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset; and
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

## Mitigating Staff Shortages:

### Allowing Staff on Quarantine to Work:

During crisis staff shortages, asymptomatic staff on quarantine due to unprotected exposure to COVID-19 may continue to work under certain precautions below, but otherwise they must remain home and quarantined (i.e., may not go out in public places until off quarantine):

- Staff must be screened for fever and symptoms of COVID-19 each day before starting work, including having their temperature taken daily.
- Staff must wear a surgical facemask (for source control) while at work and within the facility.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control
- If staff develop even mild symptoms consistent with COVID-19, they must cease patient care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.
- If staff are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all return to work criteria.
- Exposed staff who are asymptomatic should be tested for SARS-CoV-2 infection with a molecular test ideally on days 5-7 after their exposure, preferably before being allowed to work.
- Staff brought back to work early from quarantine must take strict precautions to separate themselves from other staff (i.e., avoid gathering with other co-workers in breakrooms and common areas), and ensure there is appropriate social distancing and masking.
- We recommend that if staff brought back to work early from quarantine are low-risk themselves for severe COVID-19 (i.e., not pregnant, elderly, or with co-morbid medical conditions), then they work with COVID-19 positive patients, if applicable to job duty/function.
- Staff who are household contacts to COVID-19 cases are at the highest risk for acquiring disease and should only be allowed back to work while on quarantine under situations of critical staffing shortages. The staff member should take steps to prevent ongoing spread of and exposure to COVID-19 in the home by implementing [CDC guidance](#).

### Allowing Staff with Suspected or Confirmed COVID-19 to Work:

This guidance should only be considered in crisis staffing shortages, when staffing resources have been exhausted and the above restrictions would result in potential for compromised resident care. Decisions taken about allowing suspected or confirmed COVID-19 individuals to work should be made in consultation with the facility's DHHS investigator or the Healthcare Associated Infections (HAI) program. Guidance from the [CDC suggests crisis capacity strategies](#) to mitigate staffing shortages may include the following strategies:

1. 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 and only in a cohort setting where there is no possibility for the HCP with confirmed COVID-19 to interact directly with other staff and patients who do NOT have COVID-19.
3. Facilities operating under critical staffing shortages might choose to allow HCP who have had a severe or critical COVID 19 infection to return to work after 10 to 15 days, instead of 20 days.

The following additional requirements must be met if implementing any of these practices to allow the HCP with confirmed COVID-19 to work in these settings with vulnerable patients:

1. Staff should feel well enough to work and tolerate wearing full PPE.

2. Assess HCP symptoms and fitness for work before each shift.
3. Remind the HCP that in addition to potentially exposing patients, they could also expose their co-workers. The HCP must pay strict attention not to enter areas without COVID-19 patients and cannot interact with other staff who are without COVID-19.
4. Facemasks must be worn at all times, even when they are in non-patient care areas such as breakrooms.
5. If they must remove their facemask (e.g., to eat or drink), they should separate themselves from others ideally in a room dedicated for only COVID-19 positive staff.
6. Use a separate entrance/exit and a dedicated route to get to and from the COVID-19 unit in order to avoid viral shedding in areas of the facility that are not COVID-19 contaminated.
7. Perform frequent hand hygiene with an alcohol-based hand sanitizer, or frequent hand washing
8. Additional environmental disinfection should be used in areas that are dedicated to the HCP with confirmed COVID-19.
9. While allowed to work under the above restrictions, the HCP with confirmed COVID-19 must otherwise isolate at home until removed from isolation. They may not, for example, go out into other public settings like the grocery store.
10. The facility should be prepared for the HCP with confirmed COVID-19 to develop worsening symptoms that may prevent them from working, so should make contingency staffing plans.

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<sup>i</sup> Persons with COVID-19 who are considered severely immunocompromised include those who are:

- Receiving chemotherapy for hematopoietic malignancies
- Receiving chemotherapy or radiation for solid-organ malignancies
- Immunosuppressed following solid-organ transplant, or during conditioning and 12 months following hematopoietic stem cell transplant
- Taking biologic therapy (rituximab, IL-17, IL-6, or TNF inhibitors)
- Receiving at least 20 mg or 2 mg/kg body weight of prednisone (or equivalent) per day for 14 or more days
- Immunosuppressed because of severe inherited or acquired immunodeficiencies (e.g., agammaglobulinemia or HIV infection with CD4 count less than 200)

<sup>ii</sup> 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.

<sup>iii</sup> 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.