

This document has been significantly updated to align with current public health guidance.

Return to work criteria for healthcare personnel (HCP) with SARS-CoV-2 Infection

Facilities are expected to operate at the highest level possible and maintain adequate staffing levels. Refer to the CDC *Strategies to Mitigate HCP Staffing Shortages* at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html> to explore measures to reduce anticipated staffing shortages. For example, in the event shortage of testing supplies will not allow a facility to maintain adequate staffing levels, then they may operate under *contingency* or even *crisis* strategies. **Facilities should return to *conventional* staffing strategies as soon as resources permit, including adequate testing.** For full guidance, please see CDC *Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2* at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

SYMPTOM-BASED STRATEGY



HCP who are not moderately to severely immunocompromised¹ with mild² to moderate³ illness should remain on isolation until **10 DAYS** have passed since symptoms first appeared (20 days for severe⁴ or critical⁵ illness) **AND** at least 24 hours have passed since resolution of fever without the use of fever-reducing medication, **AND** improvement in symptoms. **NOTE:** If at *contingency* capacity staffing and HCP is mildly symptomatic, HCP can return to work in 5 days with improving symptoms. If at *crisis* capacity staffing, facilities can prioritize staff remaining at work.

TIME-BASED STRATEGY



Asymptomatic HCP who are not moderately to severely immunocompromised should remain on isolation until **10 DAYS** have passed since the date of first positive SARS-CoV-2 viral diagnostic test (20 days for those who are moderately to severely immunocompromised) **AND** have **remained asymptomatic** (if symptoms appear during this time refer to above). **NOTE:** If at *contingency* capacity staffing, and HCP remains asymptomatic, HCP can return to work in 5 days. If at *crisis* capacity staffing, facilities can prioritize staff remaining at work.

CONVENTIONAL TEST-BASED STRATEGY



In addition to the criteria outlined above, if at conventional staffing, return to work may be reduced to **7 DAYS** with a negative viral test obtained within 48 hours prior to returning to work. If testing results positive, that HCP may return to work 10 days from initial test and/or symptom onset. **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 moderately to severely immunocompromised HCP may return to work.**

Illness severity definitions

¹ The degree of immunocompromise in the HCP is ultimately determined by the treating provider; however, some conditions such as receiving chemotherapy for cancer, being within one year out from receiving hematopoietic stem cell or solid organ transplant, 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 require actions such as lengthening the duration of HCP work restrictions. 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 occupational health actions to prevent disease transmission.

² 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.

³ Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and oxygen saturation (SpO₂) ≥94% on room air at sea level.

⁴ 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%.

⁵ Critical Illness: Individuals with respiratory failure, septic shock, and/or multiple organ dysfunction.

HCP exposure risk assessment guidance

As resources permit, healthcare facilities should continue utilizing formal healthcare personnel[^] (HCP) risk assessments for exposure to SARS-CoV-2 using the updated NJDOH Risk Assessment Algorithm located at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml. Updates include assessing HCP use of a respirator when the COVID-19 positive person is not using source control and whether or not the exposed HCP has received all CDC recommended COVID-19 vaccines, including a booster. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, a conservative approach to HCP monitoring and applying work restrictions is recommended to prevent transmission from potentially contagious HCP to patients/residents, other HCP, and visitors. Occupational health programs should have a low threshold for evaluating symptoms and testing HCP. In general, work restriction of asymptomatic HCP who received all recommended COVID-19 vaccine and booster doses is NOT recommended unless they:

- Develop symptoms; or
- Test positive for SARS-CoV-2 infection; or
- Are moderately to severely immunocompromised; or
- Are otherwise directed to do so by the jurisdiction's public health authority

If HCP have not received all recommended COVID-19 vaccine and booster doses (despite eligibility), work restrictions still apply; this includes individuals who were positive for SARS-CoV-2 within the prior 90 days. HCP who have traveled should continue to follow CDC work restriction guidance and refer to the NJ COVID-19 Information Hub at <https://covid19.nj.gov/faqs/nj-information/travel-and-transportation/are-there-travel-restrictions-to-or-from-new-jersey>. 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. If staffing shortages occur, it might not be possible to maintain conventional strategies. Healthcare facilities should incorporate their occupational health program, if applicable, in the assessment and management of risk for implementing contingency and crisis staffing strategies. Refer to the CDC **Strategies to Mitigate HCP Staffing Shortages** at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>.

HCP testing results guidance (viral testing only, not serology)

HCP with even mild symptoms of COVID-19 should be prioritized for viral testing, **regardless of vaccination status**. Ensure that SARS-CoV-2 testing is performed with a test capable of detecting SARS-CoV-2, specifically with currently circulating variants in the United States. Refer to the FDA SARS-CoV-2 Viral Mutations: Impact on COVID-19 Tests at <https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/sars-cov-2-viral-mutations-impact-covid-19-tests>.

1) COVID-19 Positive HCP

When testing HCP for SARS-CoV-2 is indicated, negative results from at least one FDA Emergency Use Authorized COVID-19 viral test (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html>) indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 RNA may be performed at the discretion of the evaluating clinician, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists. Consultation with an infectious disease expert should be considered to resolve any discrepant results. **Upon meeting the return-to-work criteria, all HCP who have tested positive or diagnosed with COVID-19 should adhere to core infection prevention and control principles, continue to monitor for symptoms, and seek re-evaluation from occupational health if symptoms of COVID-19 (re)occur or worsen.**

2) COVID-19 Negative HCP

- Asymptomatic HCP tested negative:** Work restrictions based on staffing level at facilities (see below) . HCP should continue to report recognized exposures, regularly monitor themselves for fever and symptoms of COVID-19, utilize well-fitting source control, and not report to work when ill.

- Under **conventional** staffing strategies, asymptomatic HCP with a higher-risk exposure who have not received all recommended COVID-19 vaccine and booster doses (despite eligibility), should be excluded from work. These HCP are permitted to return to work if they remain asymptomatic and test negative 7 days after exposure, or 10 days after exposure with no test.
 - Under **contingency** staffing strategies, asymptomatic HCP with a higher-risk exposure who have not received all recommended COVID-19 vaccine and booster doses (despite eligibility), can be permitted to continue to work. These HCP should be tested 1 day after the exposure (day 0) and, if negative, again 2, 3, and 5-7 days after the exposure. **If testing supplies are limited, testing should be prioritized for 1-2 days after the exposure and, if negative, 5-7 days after exposure.**
- b) **Symptomatic HCP tested negative:** Symptomatic HCP who test negative for COVID-19 may have another respiratory virus. Similar guidance on infection prevention and control should be followed (e.g., isolated from others, practice good hand hygiene, clean and disinfect environmental surfaces). If HCP has an alternate diagnosis (e.g., tested positive for influenza), the criteria for returning to work should be based on that diagnosis. **At a minimum, HCP should be excluded from work for at least 24 hours after symptoms resolve** including fever without the use of fever-reducing medications, if applicable. Consult your facility's occupational health policy for return to work after illness criteria.

Resources

CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

CDC Strategies to Mitigate HCP Staffing Shortages
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>