**PENNSYLVANIA DEPARTMENT OF HEALTH**

**2022 – PAHAN – 616 – 1-5 - UPD**

# UPDATE: Work Restrictions for Healthcare Personnel with Exposure to COVID-19

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| **DATE:** | 1/5/2022 |
| **TO:** | Health Alert Network |
| **FROM:** | Keara Klinepeter, Acting Secretary of Health |
| **SUBJECT:** | **UPDATE: Work Restrictions for Healthcare Personnel with Exposure to COVID-19** |
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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

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, this guidance is being updated to enhance protection for healthcare personnel (HCP), patients, and visitors, and to address concerns about potential impacts on the healthcare system given a surge of SARS-CoV-2 infections. These updates will be refined as additional information becomes available to inform recommended actions. Updates include:

- The definition of higher-risk exposure was updated to include use of a facemask (instead of a respirator) by HCP if the infected person is not also wearing a facemask or cloth mask.
- Added options to mitigate staffing shortages that would allow asymptomatic HCP with a higher-risk exposure who have not received all COVID-19 vaccine doses, including booster dose, as recommended by CDC to return to work prior to the previously recommended 14-day post-exposure period of work restriction, assuming they do not develop symptoms or test positive for SARS-CoV-2.

**This guidance replaces PA-HAN-596.** Additions are written in red. If you have additional questions about this guidance, please contact DOH at 1-877-PA- HEALTH (1-877-724-3258) or your local health department.

This guidance replaces PA-HAN-596 and includes the following sections:

1. Background
2. Definition of a higher-risk exposure for HCP
    a. Community-related exposure
    b. Household exposure
    c. Exposure in the healthcare setting while at work
3. Criteria for reducing work exclusion for HCP with higher-risk exposure to mitigate staffing shortages

## 1. BACKGROUND

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 and residents, other HCP, and visitors. Occupational health programs should have a low threshold for evaluating any potential symptoms of COVID-19 and testing HCP.

This guidance describes the process for contact tracing and application of work restrictions that should occur when capacity exists to perform these activities without compromising other critical infection prevention and control functions. If a healthcare facility is not performing contact tracing and work restrictions as outlined in this guidance, they must be operating according to the facility's emergency management plan.

This guidance is based on currently available data about COVID-19. Occupational health programs should use clinical judgement as well as the principles outlined in this guidance to assign risk level and determine the need for work restrictions.

## 2. DEFINITION OF A HIGHER-RISK EXPOSURE FOR HCP

The term **higher-risk exposure** has been used by CDC and the Department to outline when work restriction should occur for HCP following exposure to COVID-19. **A higher-risk exposure includes any exposure to COVID-19 that meets the criteria outlined below for community-related exposure, for household exposure, or for higher-risk exposure in the healthcare setting while at work.**

### a. Community-related exposure

As outlined in the CDC guidance for community-related exposure to COVID-19, persons who have had close contact (within 6 feet for a total of 15 minutes or more) with an infectious person with COVID-19 are considered exposed. Other activities of shorter duration may also be considered close contact, like providing care for a sick person, hugging or kissing them, sharing dishware or utensils, and having been coughed or sneezed upon by an infectious person.

Note that when an HCP is exposed to COVID-19 within a healthcare setting as a *patient or visitor*, the criteria for community-related exposure apply.

### b. Household exposure

An infectious person living in the home with an HCP represents an exposure to that HCP except in the unusual situation that the HCP was not in the home at any point during the infectious period (for example, HCP had been away on vacation or staying elsewhere). In most cases, it is not appropriate to apply the close contact criteria for household exposure, because even if two persons in the home are not in direct contact with each other (e.g., as reported sometimes by roommates who work different shifts), the shared environment represents a level of risk consistent with higher-risk exposure.

### c. Exposure in the healthcare setting while at work

**Higher-risk exposures in the healthcare setting** generally involve exposure of HCP eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure. Other exposures classified as lower-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth. In general, work restrictions and testing are not required for HCP with a lower-risk exposure, which is defined as any exposure other than a higher-risk exposure described in Table 2. The specific factors associated with these exposures should be evaluated on a case-by-case basis and restriction from work can be applied if the risk for transmission is deemed substantial. *Exposures can also be from a person under investigation (PUI) if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to PUIs should be maintained.*

The framework presented in Table 1 is considered the conventional and recommended return to work strategy for healthcare settings. Contingency and crisis strategies are described in Section 3.

**Table 1. Recommended Work Restrictions for HCP Based on Vaccination Status and Type of Exposure**

| Exposure | Personal Protective Equipment (PPE) used | Work Restriction for HCP who have received all COVID-19 vaccine and booster doses* | Work Restriction for HCP who have not received all COVID-19 vaccine and booster doses† |
|---|---|---|---|
| Higher-risk: HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection[3] | • HCP not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)[4] | • In general, no work restrictions.[5]<br>• Perform SARS-CoV-2 testing immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure.[6] | **Option 1:**<br>• Exclude from work. HCP can return to work after day 7 following the exposure (day 0) if a viral test[6] is negative for SARS-CoV-2 and HCP do not develop symptoms. The specimen should be collected and tested |

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| | • HCP not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask<br><br>• HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure[1] | • Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.<br><br>• Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. | within 48 hours before the time of planned return to work (e.g., in anticipation of testing delays).<br><br>**Option 2:**<br>• Exclude from work. HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms. Although the residual risk of infection is low, healthcare facilities could consider testing[6] for SARS-CoV-2 within 48 hours before the time of planned return.<br><br>**In addition to Options above:**<br>• Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.<br><br>• Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. |

*At least two weeks have passed since receipt of the booster dose. See Definitions for a full description of boosted.

†HCP who have not received all COVID-19 vaccine and booster doses or are within two weeks of receiving the booster dose.

HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. 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 above.

**Table 1 Footnotes:**

1. Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, it is reasonable to consider an exposure of 15 minutes or more as prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, **any duration** should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.
2. Data are limited for the definition of close contact. For this guidance close contact is defined as a) being within 6 feet of a person with confirmed COVID-19 or b) having unprotected direct contact with infectious secretions or excretions of a person with confirmed COVID-19. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.
3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 could have been infectious:
    a. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 48 hours before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions in PA-HAN 597 or its successor.
    b. For individuals with confirmed COVID-19 who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with COVID-19 may have been exposed could help inform the period when they were infectious.
        1. In general, asymptomatic individuals with COVID-19 should be considered potentially infectious beginning 2 days after their exposure until they meet criteria for discontinuing Transmission-Based Precautions in PA-HAN 597 or its successor.
        2. If the date of exposure cannot be determined, although the infectious period could be longer, contact tracing should be conducted using a starting point of 2 days prior to the specimen collection date through the time period when the individual meets criteria for discontinuing Transmission-Based Precautions in PA-HAN 597 or its successor.
4. While respirators provide a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still provide some level of protection to HCP, which was factored into this risk assessment. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown.
5. Circumstances when work restriction might be recommended:

a. HCP are moderately to severely immunocompromised.
b. When directed by public health authorities (e.g., during an outbreak where SARS-CoV-2 infections are identified among HCP who have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC)
    1. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of work restriction of HCP with higher-risk exposures who have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC. In addition, there might be other circumstances for which the jurisdiction's public health authority recommends these and additional precautions.

6. Either an antigen test or NAAT can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

## 3. CRITERIA FOR REDUCING WORK EXCLUSION FOR HCP WITH HIGHER-RISK EXPOSURE TO MITIGATE STAFFING SHORTAGES

For exposed HCP who have not received all COVID-19 vaccine and booster doses, or are within two weeks of receiving the booster dose, exclude HCP with a higher-risk exposure as outlined in Table 1 unless the facility is implementing strategies for mitigating staffing shortages. These strategies are outlined in detail in the CDC guidance and represent a continuum of options for addressing staffing shortages. A summary of the strategies can be found in Table 2. Contingency and crisis capacity strategies augment conventional strategies and are **meant to be considered and implemented sequentially** (i.e., implementing contingency strategies before crisis strategies).

Prior to allowing exposed HCP to work, all of the following criteria must be met by the healthcare facility:

- Exclusion of the exposed HCP would mean there would no longer be enough staff to provide safe patient care.
- Other contingency capacity strategies have been exhausted (see CDC strategies). These include:
    - Cancelling all non-essential procedures and visits. Shifting HCP who work in these areas to other patient care areas. Ensure HCP receive appropriate orientation and training in areas that are new to them.
    - Adjust staff schedules and offer incentives for working off-schedule or additional hours.
    - Attempt to address social factors that might prevent HCP from reporting to work such as need for transportation or housing that allows for social distancing, particularly if HCP live with individuals with underlying medical conditions or older adults that are not fully vaccinated.
        - Consider that these social factors disproportionately affect persons from some racial and ethnic groups, who are also disproportionally affected by COVID-19 (e.g., African Americans, Hispanics and Latinos, and

American Indians and Alaska Natives).

- Identify means of hiring additional HCP. Refer to state-specific waivers that may facilitate hiring.
- As appropriate, work with HCP to ensure a balance is maintained between work demands and scheduled leave. Consideration should be given to the mental health benefits of time off and the care-taking responsibilities that may differ substantially among staff.

- **The facility has met criteria for contingency or crisis capacity standards for staffing as defined in their emergency management plan.**

Options to allow exposed HCP to continue to work represent a spectrum of risk to patients, visitors and other HCP in the facility. Based on current understanding of the transmission of COVID-19, a suggested risk continuum is given below for exposed HCP. These decisions should be outlined in the facility-specific emergency management plan.

- These HCP should still report temperature and absence of symptoms each day before starting work.
- They should use a respirator or well-fitting facemask at all times in the facility.
- If HCP develop even mild symptoms consistent with COVID-19, they should either not report to work, or stop working and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.
- If HCP are tested and found to be infected with SARS-CoV-2, they should ideally be excluded from work until they meet all Return to Work Criteria outlined in PA-HAN 614 or its successor. HCP with suspected SARS-CoV-2 infection should be prioritized for testing, as testing results will impact when they may return to work and for which patients they might be permitted to provide care.

**Strategies for mitigating staffing shortages:**

- **Contingency capacity:** Allow asymptomatic HCP who 1) had a higher-risk exposure to SARS-CoV-2 and 2) are not known to be infected with SARS-CoV-2 and 3) have not received all COVID-19 vaccine doses, including booster dose, or are within two weeks of receiving the booster dose, to continue to work onsite throughout their 14-day post-exposure period:

  If permitted to work, these HCP should be tested* 1 day after the exposure (day 0) and, if negative, again on days 2 and 3, and once more on day 5-7 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.

*Either an antigen test or nucleic acid amplification test (NAAT) can be used. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

**Crisis Capacity**: Allow asymptomatic HCP who 1) had a higher-risk exposure to SARS-CoV-2 and 2) are not known to be infected with SARS-CoV-2 and 3) have not received all COVID-19 vaccine doses, including booster dose, or are within two weeks of receiving the booster dose, to continue to work onsite throughout their 14-day post-exposure period without testing.

**Table 2. Summary of Strategies for Mitigating Staffing Shortages by Vaccination Status for Asymptomatic HCP with Exposures**

| Vaccination Status | Conventional | Contingency | Crisis |
|---|---|---|---|
| Boosted | No work restrictions, with negative test on days 2† and 5-7 | No work restrictions | No work restrictions |
| Vaccinated or Unvaccinated, even if within 90 days of prior infection | 10 days OR 7 days with negative test | No work restrictions with negative tests on days 1†, 2, 3, & 5-7 | No work restrictions (test if possible) |

†For calculating day of test: consider day of exposure as day 0

Any HCP who develop fever or symptoms consistent with COVID-19 should immediately leave work and contact their established point of contact (e.g. occupational health program) to arrange for medical evaluation and testing. Healthcare facilities should follow guidance in PA-HAN-541 or its successor if signs and symptoms occur in the 3 days following vaccine.

**Definitions:**

**Boosted:** Receipt of a booster dose of COVID-19 vaccine at the recommended interval after completion of a primary series of COVID-19 vaccine and at least two weeks have passed since receipt of the booster dose.

**Fully vaccinated** is defined in the CDC Interim Public Health Recommendations for Fully Vaccinated People.

**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 the healthcare provider is determined by the treating provider, and preventive actions are tailored to each individual and situation.

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

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 January 5, 2022 but may be modified in the future. We will continue to post updated information regarding the most common questions about this subject.