RETURN TO WORK: Guidelines for Colleagues Returning Post-COVID-19 Illness

Updated August 11, 2020

What's new: Updated to reflect current CDC recommendations to use symptom-based criteria for return to work, added definitions on severity of infection and role, if applicable, of underlying immunocompromised condition, and highlight value of testing of the symptomatic colleague.

This guidance is intended to help healthcare managers and colleagues make decisions about return to work for colleagues with confirmed COVID-19 or who have suspected COVID-19; but have not been tested for COVID-19.

Definitions: 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 colleagues at any point in their clinical course should be used when determining when they may return to work.

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) ≥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.

Immunocompromised: For the purposes of this guidance, the following definition was created by the CDC to more generally address colleague occupational exposures.

- 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 require actions such as lengthening the duration of colleague 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.

Symptoms of COVID-19 usually include cough or shortness of breath; OR at least two of the following:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
• Diarrhea

I. Initial Steps for Decision Making & Testing of Colleague:

Decisions about return to work for colleagues with SARS-CoV-2 infection should be made in the context of local circumstances. In general, a symptom-based strategy should be used. **A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in excluding from work colleagues who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.**

The time period used for return to work depends on the colleague's severity of illness and if they are severely immunocompromised (see definitions in the box above).

**Colleagues with symptoms of COVID-19 should be prioritized for viral testing with approved nucleic acid or antigen detection assays.** When a clinician decides that testing a colleague for SARS-CoV-2 is indicated, negative results from at least one COVID-19 molecular viral assay for detection of SARS-CoV-2 RNA 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 healthcare provider, specifically when a higher level of clinical suspicion for SARS-CoV-2 infection exists.

- For colleagues who were suspected of having COVID-19 and COVID-19 was ruled out by either a negative clinical test or a clinical decision that COVID-19 is not suspected and testing is not indicated, then return to work decisions should be based on the suspected or confirmed diagnoses.

II. RETURN TO WORK CRITERIA FOR COLLEAGUES WITH SUSPECTED OR CONFIRMED COVID-19

**NOTES**

- Colleagues with symptoms following exposure are in Tier 1 (top) priority for in-house testing. Make every attempt to collect a specimen for testing of the colleague and use the result in combination with severity of illness and, if applicable, underlying immunocompromised condition for symptom or test-based pathways below.

- If the colleague's test is negative and there is no suspicion of COVID-19 the colleague may return to work following ministry Employee Health Services / HR policy for the suspected/diagnosed illness.

**a) Use of a Symptom-Based Strategy for Determining When Colleagues May Return to Work:**

Colleagues with **mild to moderate illness** who are not severely immunocompromised, exclude from work until:

- At least 10 days have passed since symptoms first appeared
- At least 24 hours have passed since recovery defined as resolution of fever without the use of fever-reducing medications and
- Symptoms have improved

**Notes:** Colleagues 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.

**Colleagues with severe to critical illness** OR who are severely immunocompromised:

- 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 have improved
Note: Colleagues who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 20 days have passed.

Because the majority of severely or critically ill patients no longer had replication-competent virus 10 to 15 days after onset of symptoms, facilities operating under critical staffing shortages may choose to allow colleagues to return to work after 10 to 15 days, instead of 20 days. Consider consulting with ministry Occupational Health when making return to work decisions, especially for individuals who might remain infectious longer than 10 days (e.g., severely immunocompromised). If the colleague had COVID-19 ruled out and had an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Use of a Test-Based Strategy for Determining When Colleagues May Return to Work
In a rare instance, a test-based strategy could be considered to allow colleagues to return to work earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some colleagues, as in the case of those who are severely immunocompromised, in consultation with infectious diseases providers, if concerns exist that the colleague may be infectious for more than 20 days.

The criteria for the test-based strategy are:

**Colleagues who are symptomatic:**
- Resolution of fever without the use of fever-reducing medications and
- Improvement in symptoms, and
- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

**RETURN TO WORK PRACTICES AND WORK RESTRICTIONS**

After returning to work, colleagues should:
- Wear a procedure mask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A procedure mask instead of a cloth face covering should be used by these colleagues for source control during this time period while in the facility. After this time period, these colleagues should revert to their facility policy regarding universal source control during the pandemic.
  - A procedure mask for source control does not replace the need to wear a N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19. (Of note, N95 or other respirators with an exhaust valve are not able to provide source control).
- Self-monitor for symptoms, and seek re-evaluation from their occupational health if respiratory symptoms recur or worsen

FOR EXCEPTIONAL STAFFING SHORTAGES, REFER TO YOUR INCIDENT COMMAND FOR NEXT STEPS.

**References**