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Previous updates This interim guidance is intended to assist with the following:

Guidance addressing recommended infection prevention and control practices including use of source control by HCP is available in Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

Employers should be aware that other local, territorial, tribal, state, and federal requirements may apply, including those promulgated by the Occupational Safety and Health Administration (OSHA).

HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses. The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified. HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: \*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later HCP who were asymptomatic

throughout their infection and are not moderately to severely immunocompromised could return to work after the following criteria have been met: \*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to Preventing Spread of Respiratory Viruses When You're Sick. HCP who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Test-based strategy HCP who are symptomatic could return to work after the following criteria are met: HCP who are not symptomatic could return to work after the following criteria are met: Exposures that might require testing and/or restriction from work can occur both while at work and in the community. Higher-risk exposures generally involve exposure of HCP's 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 not classified as higher-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. When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission. For the purposes of this guidance, higher-risk

exposures are classified as HCP who had prolonged<sup>1</sup> close contact<sup>2</sup> with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection<sup>3</sup> and: Following a higher-risk exposure, HCP should: Work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, regardless of vaccination status. Examples of when work restriction may be considered include: If work restriction is recommended, HCP could return to work after either of the following time periods: In addition to above: 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.

**Footnotes:** Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, 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, and 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 Interim Clinical Considerations for Use of COVID-19 Vaccines. 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>)  $\geq 94\%$  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.

**Fever:** For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0°F (37.8°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs]).

**Facemask:** OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as

‘medical procedure masks’.” Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays. Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare. Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel. Guidance on design, use, and maintenance of cloth masks is available. As of December 23, 2021 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. As of September 10, 2021 The interim guidance was updated to: As of March 10, 2021 As of February 16, 2021: Updates as of Dec 14, 2020: To receive email updates about COVID-19, enter your email address:

