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Three Key Takeaways for Health Care Employers from April 14, 2020 CDC Guidance

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On April 14, 2020, the Centers for Disease Control and Prevention (CDC) updated its various guidance on COVID-19 in health care settings. In addition to other helpful information about infection control and personal protective equipment (PPE), the CDC addressed three important employment issues related to health care employees. The guidance and links to the separate documents are below. The guidance addressing strategies for mitigating health care personnel (HCP) shortages is particularly important for long term care providers, who should follow it as closely as possible, so they can point to their adherence in response to lawsuits alleging they did not adequately staff the facility.

When reviewing and implementing strategies addressed in the CDC guidance, the differences between cloth face coverings, facemasks and respirators are important to keep in mind:

- **Cloth face covering:** Textile (cloth) cover that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE and it is uncertain whether cloth face coverings protect the wearer.** Guidance on design, use, and maintenance of cloth face coverings is available.
- **Facemask**: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks 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. Facemasks that are not regulated by FDA, 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 the CDC/NIOSH, including those intended for use in health care.

Monitor and Manage Ill and Exposed Health Care Personnel

- Facilities and organizations providing health care should implement sick leave policies for HCP that are non-punitive, flexible and consistent with public health guidance.
- As part of routine practice, HCP should be asked to regularly monitor themselves for fever and symptoms of COVID-19.
  - HCP should be reminded to stay home when they are ill.
  - If HCP develop fever (T≥100.0°F) or symptoms consistent with COVID-19* while at work, they should keep their cloth face covering or facemask on, inform their supervisor and leave the workplace.
- Screen all HCP at the beginning of their shift for fever and symptoms consistent with COVID-19*
  - Actively take their temperature and document absence of symptoms consistent with COVID-19*. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.

- *Fever is either measured temperature ≥100.0°F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed or taking certain medications (e.g., NSAIDs). Clinical judgment should be used to guide testing of individuals in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath and sore throat. Medical evaluation may be warranted for lower temperatures (<100.0°F) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by occupational health. Additional information about clinical presentation of patients with COVID-19 is available.

- HCP with suspected COVID-19 should be prioritized for testing.
- Information about when HCP with confirmed or suspected COVID-19 may return to work is available in the Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19.
- As community transmission intensifies within a region, benefits of formal contact tracing for exposures in health care settings might be limited unless residing in a community that is not yet affected by COVID-19. Health care facilities should consider foregoing contact tracing in favor of universal source control for HCP and screening for fever and symptoms before every shift.
- As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness or need to care for family members at home. Health care facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing resources to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are available.

Return to Work Criteria for HCP with Confirmed or Suspected COVID-19

Use the *Test-based strategy* as the preferred method for determining when HCP may return to work in health care settings:

1. *Test-based strategy.* Exclude from work until

   - Resolution of fever without the use of fever-reducing medications, **and**
   - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
   - Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19)).
     - All test results should be final before isolation is ended. Testing guidance is based upon limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract (nasopharyngeal swab) specimens.

If the *Test-based strategy* cannot be used, the *Non-test-based strategy* may be used for determining when HCP may return to work in health care settings:

2. *Non-test-based strategy*. Exclude from work until

   - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
   - At least 7 days have passed *since symptoms first appeared.*

HCP with laboratory-confirmed COVID-19 who have not had any symptoms should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

If HCP had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the health care facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an 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 might not provide source control.
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset.
- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.

Strategies to Mitigate Health Care Personnel Staffing Shortages

Maintaining appropriate staffing in health care facilities is essential to providing a safe work environment for HCP and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness or need to care for family members at home. Health care facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including providing resources to assist HCP with anxiety and stress and considerations for permitting HCP to return to work without meeting all return to work criteria above. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information.

There are contingency and crisis capacity strategies that health care facilities should consider in these situations. For example, if, despite efforts to mitigate, HCP staffing shortages occur, health care systems, facilities, and the appropriate state, local, territorial and/or tribal health authorities might determine that HCP with suspected or confirmed COVID-19 could return to work before the full return to work criteria have been met. Several of the crisis capacity strategies are dependent on HCP wearing a facemask for source control while at work. Given ongoing shortages of PPE, facilities should refer to and implement relevant strategies for optimizing the supply of facemasks.

When staffing shortages are anticipated, health care facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. At baseline, health care facilities must:

- Understand their staffing needs and the minimum number of staff needed to provide a safe work environment and patient care.

- Be in communication with local health care coalitions, federal, state and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed.

Contingency capacity strategies for health care facilities include:

- Adjusting staff schedules, hiring additional HCP and rotating HCP to positions that support patient care activities.
  - Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation and training to work in these areas that are new to them.
  - Attempt to address social factors that might prevent HCP from reporting to work, such as transportation or housing if HCP live with vulnerable individuals.
  - Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
  - Request that HCP postpone elective time off from work.
- Developing regional plans to identify designated health care facilities or alternate care sites with adequate staffing to care for patients with COVID-19.
- Developing plans to allow asymptomatic HCP who have had an unprotected exposure to the virus that causes COVID-19 to continue to work.
  - These HCP should still report temperature and absence of symptoms each day before starting work. These HCP should wear a facemask (for source control) while at work for 14 days after the exposure event. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - 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 HCP 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.
- Prioritizing HCP with suspected COVID-19 for testing, as testing results will impact when they may return to work and for which patients they might be permitted to provide care.
- Developing criteria to determine which HCP with suspected or confirmed COVID-19 (who are well enough to work) could return to work in a health care setting before meeting all return to work criteria — if shortages continue despite other mitigation strategies.
  - Considerations include:
    - The type of HCP shortages that need to be addressed.
    - Where HCP are in the course of their illness (e.g., viral shedding appears to be higher earlier in the course of illness).
    - The types of symptoms they are experiencing (e.g., persistent fever).
    - Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
    - The type of patients they care for (e.g., immunocompromised patients).

- As part of planning, health care facilities (in collaboration with risk management) should create messaging for patients and HCP about actions that will be taken to protect them from exposure to SARS-CoV-2 if HCP with suspected or confirmed COVID-19 are allowed to work.

Crisis Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are occurring, health care facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care.

When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to designated health care facilities, or alternate care sites with adequate staffing
- If not already done, allow asymptomatic HCP who have had an unprotected exposure to the virus that causes COVID-19 to continue to work.

  - These HCP should still report temperature and absence of symptoms each day before starting work. These HCP should wear a facemask (for source control) while at work for 14 days after the exposure event. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - 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 HCP 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 shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are well enough to work but have not met all return to work criteria to work. If HCP are allowed to work before meeting all criteria, they should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:

  1. If not already done, 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, preferably in a cohort setting.
  3. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
  4. As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients *without* suspected or confirmed COVID-19.
- If HCP are permitted to return to work before meeting all return to work criteria, they should still adhere to all return to work practices and work restrictions recommendations described in that guidance. These include:

  - Wear a facemask for source control at all times while in the health care facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. A facemask instead of a cloth face covering should be used by these HCP for source control during this time

period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including 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.
  - They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
    - Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
    - If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others.
- Being restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until the full return to work criteria have been met.
- Self-monitoring for symptoms and seeking re-evaluation from occupational health if respiratory symptoms recur or worsen.