



DPH Guidance for Management of Persons with Suspected COVID-19 Exposure, Discontinuation of Home Isolation and Return to Work

This document is intended to serve as guidance for health care providers for discontinuation of home isolation as well as return-to-work guidance for patients with suspected, presumed, or confirmed coronavirus disease 2019 (COVID-19) infection in the state of Delaware. Due to the dynamic nature of information which continues to emerge about COVID-19 and the virus that causes it (severe acute respiratory syndrome coronavirus 2, shortened to SARS-CoV-2), this information is subject to change.

Effective: 04/07/2020

Depending on the clinical suspicion of COVID-19, *symptomatic* PUIs for whom an initial rRT-PCR test is negative may be candidates for removal of any isolation and travel restrictions immediately. Asymptomatic persons should not undergo testing at this time as a negative result does not preempt the requirement for self-isolation completion.

Management of Potential Exposure for Health care Personnel (HCP) in a Health care Setting

This guidance applies to HCP with exposure in a health care setting to patients with confirmed COVID-19, or a patient who is diagnosed empirically with COVID-19 without confirmatory testing.

High-risk exposures refer to HCP who have had prolonged close contact with patients with COVID-19 who were not wearing a facemask, while the HCP's nose and mouth were possibly exposed to secretions potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 when the healthcare providers' eyes, nose, or mouth were not protected, is also considered *high-risk*.

Medium-risk exposures generally include HCP who had prolonged close contact with patients with COVID-19 who were wearing a facemask, while the HCP's nose and mouth were possibly exposed to secretions potentially infectious with the virus causing COVID-19. Some *low-risk* exposures are considered *medium-risk* depending on the type of care activity performed. For example, HCPs who were wearing a gown, gloves, eye protection and a facemask (instead of a



respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure. If an aerosol-generating procedure had not been performed, they would have been considered *low-risk*.

Low-risk exposures generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while HCPs were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator, would further lower the risk of exposure.

HCPs in the high- or medium-risk category should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any fever (measured temperature $\geq 100^{\circ}\text{F}$ or subjective fever) OR other symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias) they should immediately self-isolate (separate themselves from others) and notify DPH OIDE at 1-888-295-5156 and their healthcare facility promptly so that they can coordinate consultation and PCR testing for COVID-19 if indicated.

HCPs in the *low-risk* category should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. *Asymptomatic HCPs in this category are not restricted from work.* They should check their temperature twice daily and remain alert for other symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias). They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or respiratory symptoms they may report to work. If they develop fever (measured temperature $\geq 100^{\circ}\text{F}$ or subjective fever) OR other suspected COVID-19 symptoms they should immediately self-isolate (separate themselves from others) and notify DPH and their healthcare facility promptly so that they can coordinate consultation and PCR testing for COVID-19 if indicated.

Healthcare facilities should consider measuring temperature and assessing symptoms of all HCPs prior to starting work. Alternatively, facilities could consider having HCPs report temperature and symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while



at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work. Facility occupational health or infection prevention personnel should consider restricting HCP with exposure from high-risk patient care areas, including but not limited to: NICU, units housing immunosuppressed non-COVID-19 patients, or other fragile patient populations.

Management of Potential Exposure for Health Care Personnel (HCP) in a Community Setting

This guidance applies to HCPs with potential exposure in a community setting to patients with confirmed COVID-19.

Close contact is defined as:

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time (such as caring for or visiting the patient, or sitting within 6 feet of the patient in a healthcare waiting area or room); close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a diagnosed COVID-19 case (e.g., being coughed on)

High risk: Living in the same household as, being an intimate partner of, or providing care in a nonhealthcare setting (such as a home) for a person with symptomatic laboratory-confirmed COVID-19 infection **without using recommended precautions** for home care and home isolation.

Medium-risk: Close contact with a person with symptomatic laboratory-confirmed COVID-19

- On an aircraft, being seated within 6 feet (two meters) of a traveler with symptomatic COVID-19 infection; this distance correlates approximately with 2 seats in each direction
- Living in the same household as, an intimate partner of, or caring for a person in a nonhealthcare setting (such as a home) to a person with symptomatic COVID-19 infection **while consistently using recommended precautions** for home care and home isolation.



Low-risk: Being in the same indoor environment (e.g., a classroom, a hospital waiting room) as a person with symptomatic COVID-19 for a prolonged period of time but not meeting the definition of close contact, or interactions with a person with symptomatic laboratory-confirmed COVID-19 infection that do not meet any of the high-, medium- or low-risk conditions above, such as walking by the person or being briefly in the same room.

HCPs in the high-risk category should be directed to quarantine (voluntary or under public health orders) in a location to be determined by public health authorities for 14 days.

- No public activities.
- Daily active monitoring, if possible based on local priorities
- Controlled travel

HCPs in the medium-risk category should be recommended to remain at home or in a comparable setting, and not permitted to return to work for 14 days.

- Practice social distancing
- Self-monitoring by the HCP.

HCP in the low-risk category have no restriction on movement and should practice self-monitoring.

Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work. Facility occupational health or infection prevention personnel should consider restricting HCP with exposure from high-risk patient care areas, including but not limited to: NICU, units housing immunosuppressed non-COVID-19 patients, or other fragile patient populations.



Discontinuation of Home Isolation and Return to Work for SYMPTOMATIC Persons with CONFIRMED or SUSPECTED COVID-19

Options include a time-since-illness-onset and time-since-recovery (“non-test-based”) strategy and a “test-based” strategy.

Time-since-illness-onset and time-since-recovery strategy (“non-test-based” strategy)

Persons with *CONFIRMED* or *SUSPECTED* COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation under the following conditions:

- 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*.

After discontinuation of home isolation, persons must continue to avoid sustained close contact with others, maintain strict social distancing and hand hygiene, and not return to work for an additional 4 days (for a total of 7 days without symptoms) due to the possible risk of continued infectiousness. Persons may return to work after this 7-day period however should continue to recognize the risk of infectiousness and self-monitor for symptoms.

Health care personnel may be considered for return to work after 3 days following symptoms cessation however must wear a facemask, limit close contacts, and consider avoidance of high-risk patient populations until a total of 14 days following resolution of symptoms. Health care personnel should practice self-monitoring. DPH recommends that individual risk assessments for COVID-19 exposures based on setting, personnel, and type of activity be performed.

For critical infrastructure personnel/essential services workers who are deemed under crisis staffing patterns, it may be considered to allow personnel to return to work 3 days following fever resolution and improvement in respiratory symptoms. In such scenarios, personnel should be evaluated by occupational health or facility medical professionals to determine appropriateness of earlier return to work than recommended above. If personnel return to work earlier than recommended above, they must wear a facemask, limit close contacts, and consider avoidance of high-risk patient populations until a total of 14 days following resolution of symptoms. Critical infrastructure personnel/essential



services workers should practice self-monitoring. DPH recommends that individual risk assessments for COVID-19 exposures based on setting, personnel, and type of activity be performed.

Individuals with **CONFIRMED** COVID-19 who have **not** had any symptoms may discontinue home isolation when at least 7 days have passed since the date of their first positive COVID-19 diagnostic test **and** have had no subsequent illness. If there has been illness subsequent to first positive test, the individual must proceed according to the guidance for symptomatic persons with confirmed COVID-19 above.

After discontinuation of home isolation, persons may return to work however, should recognize the possible risk of continued infectiousness and must limit close contacts and continue to maintain strict social distancing and hand hygiene for at least an additional 7 days following positive test (for a total of 14 days). HCPs may return to work however should wear a facemask until a total of 14 days following positive test.

Figure 1. Flow for isolation discontinuation and return to work for non-health care personnel.

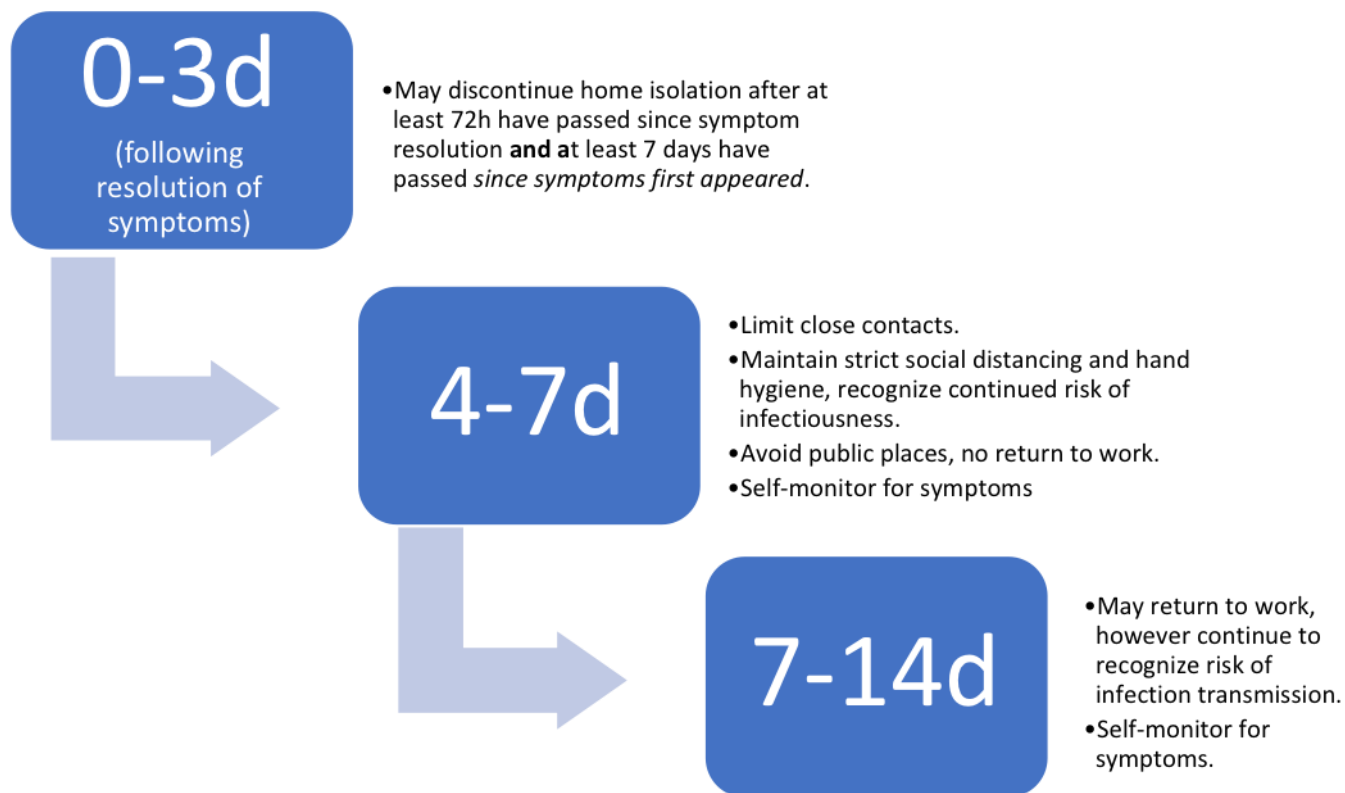




Figure 2. Flow for isolation discontinuation and return to work for health care personnel.

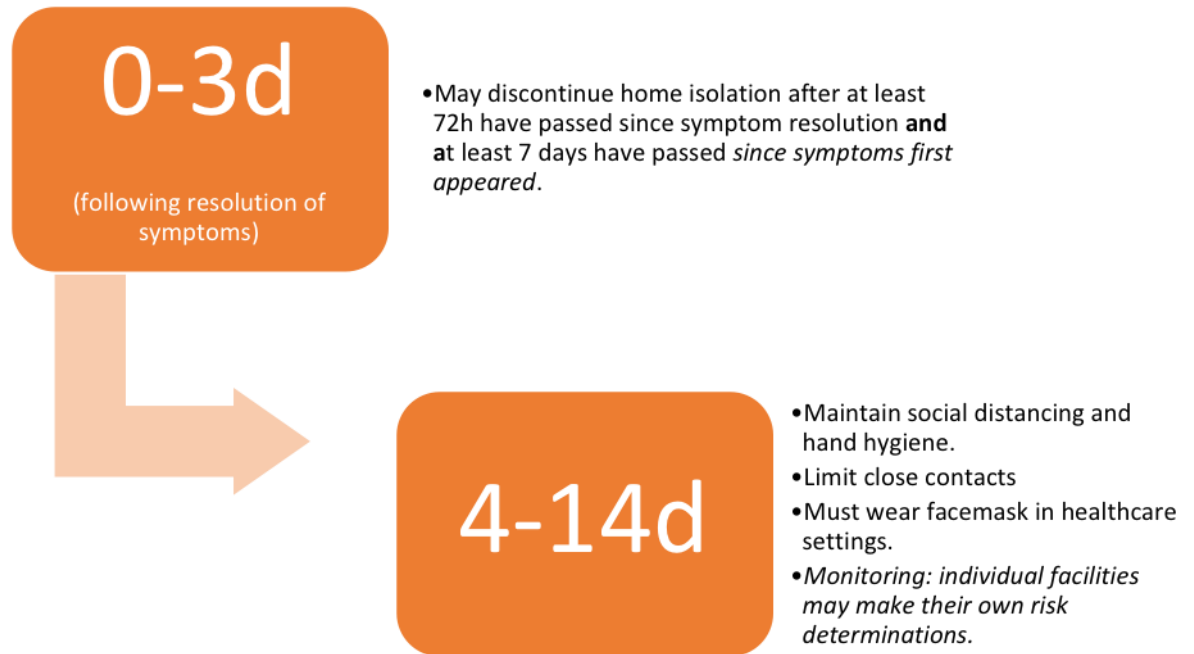
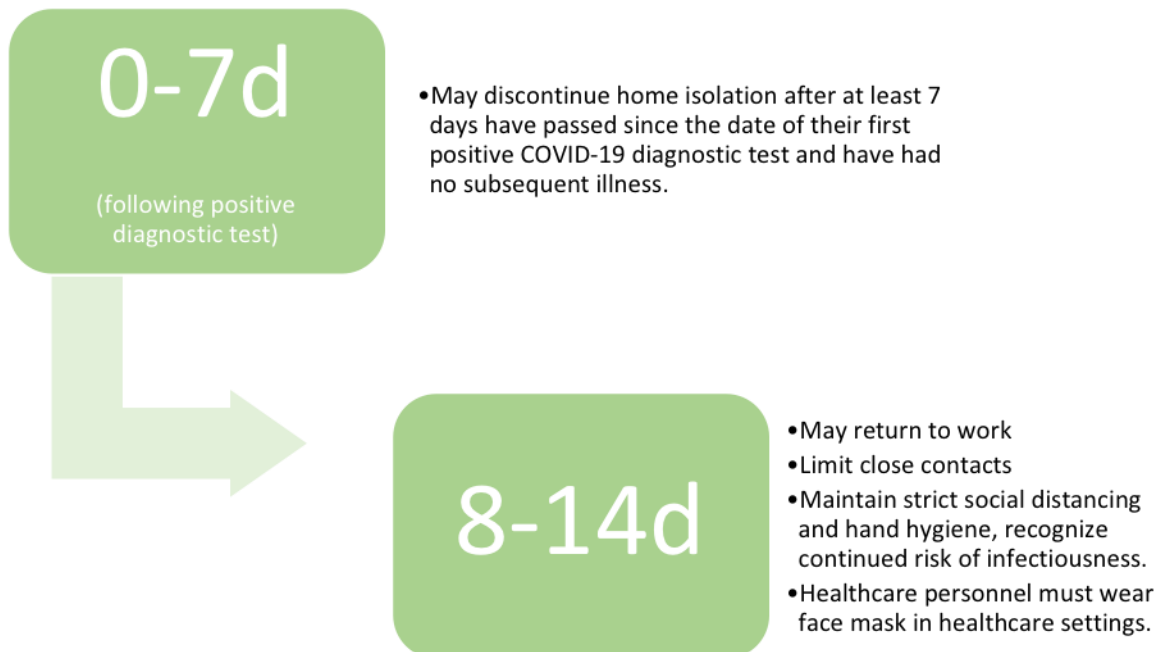


Figure 3. Flow for isolation discontinuation and return to work for persons who never manifested symptoms (asymptomatic with positive COVID-19 diagnostic test)





“Test-based” strategy (simplified from initial protocol)

A test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing. At this time, test-based strategy should **ONLY** be employed for patients with *CONFIRMED* COVID-19 infection.

Persons who have *CONFIRMED* COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation under the following conditions:

- 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)