**DPH Guidance for Management of Persons with Suspected COVID-19 Exposure, Discontinuation of Home Isolation and Return to Work (Health Care Setting)**

*This document is intended to serve as guidance for discontinuation of home isolation as well as return-to-work guidance for persons 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.*

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Depending on the clinical suspicion of COVID-19, *symptomatic* persons under investigation (PUIs) for whom an initial rRT-PCR test is negative may be candidates for removal of any isolation and travel restrictions immediately. Asymptomatic persons who are advised to self-quarantine due to having been identified as having close contact with a person infected with COVID-19 are reminded that a negative result does not preempt the requirement for self-quarantine completion.

## I. Management of Potential Exposure in a Health Care Setting

*This guidance applies to exposures in a health care setting to persons with confirmed COVID-19, or a person who is diagnosed empirically with COVID-19 without confirmatory testing.*

*High-risk* exposures refer to those who have had prolonged (more than 15 minutes) close contact with persons infected with COVID-19 who were not wearing a facemask, while the nose and mouth of the employee 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 persons infected with COVID-19 when the healthcare providers' eyes, nose, or mouth were not protected, is also considered *high-risk.*

*Medium-risk* exposures generally include those who had prolonged (more than 15 minutes) close contact with persons infected with COVID-19 who were wearing a facemask, while their own 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, those 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*. During patient care activities outside of aerosol-generating procedures, those who were wearing a gown, gloves, and a facemask (but not eye protection) would be considered *medium risk* if the person with COVID-19 was not wearing a cloth face covering or facemask.

*Low-risk* exposures generally refer to brief interactions with persons infected with COVID-19 or prolonged close contact with persons who were wearing a facemask for source control while the caregiver was wearing a facemask or respirator or prolonged close contact with persons while the caregiver was wearing all recommended PPE (i.e., gown, gloves, eye protection, facemask or respirator).

**High- or medium-risk category** should undergo active monitoring, including restriction from work in any healthcare setting until 10 days after their last exposure (or 7 days with a negative diagnostic test performed no earlier than 5 days after last exposure). They should self-monitor for symptoms, including checking temperature twice a day and watching for symptoms of COVID-19. If they develop any elevated temperature (measured temperature $\geq$ 99.5°F or subjective fever) OR other symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, shaking chills, myalgias) they should immediately self-isolate (separate themselves from others) and notify DPH OIDE at 1-888-295-5156 and their health care facility promptly so that they can coordinate consultation and testing for COVID-19 if indicated.

***Low-risk* category** should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. *Asymptomatic persons 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, shaking chills, 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 elevated temperature (measured temperature $\geq$ 99.5°F or subjective fever) OR other suspected COVID-19 symptoms they should immediately self-isolate (separate themselves from others) and notify DPH OIDE (302-744-4990 or reportdisease@delaware.gov) and their healthcare facility promptly so that they can coordinate consultation and testing for COVID-19 if indicated.

Health care facilities should consider measuring temperature and assessing symptoms of all employees prior to starting work. Alternatively, facilities could consider having employees 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 employees who have had an exposure to a person infected with COVID-19 to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These employees should still report temperature and absence of symptoms each day prior to starting work. Facilities should have exposed employees wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If the employee develops 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 the employee 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.

**Guidance for Asymptomatic HCP Who Were Exposed to Individuals with Confirmed COVID-19:**

| Exposure | Personal Protective Equipment Used | Work Restrictions |
|---|---|---|
| HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 | • HCP not wearing a respirator or facemask<br>• HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask<br>• HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure | • Exclude from work for 10 days after last exposure (or 7 days with a negative diagnostic test performed no earlierthan 5 days after last exposure).<br>• Advise HCP to monitor themselves for fever or symptomsconsistent with COVID-19<br>• Any HCP who develop fever or symptoms consistent withCOVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. |
| HCP other than those with exposure risk described above | • N/A | • No work restrictions<br>• Follow all recommended infection prevention and control practices, including wearing a facemask for source controlwhile at work, monitoring themselves for fever or symptoms consistent with COVID-19 and not reportingto work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19 at the beginning of their shift.<br>• Any HCP who develop fever or symptoms consistent withCOVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational healthprogram) to arrange for medical evaluation and testing. |

## II. Discontinuation of Home Isolation/Return to Work for SYMPTOMATIC Persons with CONFIRMED or SUSPECTED COVID-19

**Options include a time-since-illness-onset and time-since-recovery ("symptom-based") strategy and a "test-based" strategy.**

**Time-since-illness-onset and time-since-recovery strategy ("symptom-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 1 day (24 hours) has passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in symptoms (e.g., cough, shortness of breath); **and,**
- At least 10 days have passed *since symptoms first appeared*.

*Health care personnel with severe to critical illness **or** who are severely immunocompromised should extend the period of isolation and may return to work when at least 1 day (24 hours) has passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); **and** at least **20 days** have passed since symptoms first appeared*

*After discontinuation of home isolation, persons should continue to avoid sustained close contact with others and maintain strict social distancing and hand hygiene due to the possible risk of continued infectiousness. Persons may return to work; however, they should continue to recognize the risk of infectiousness and self-monitor for symptoms.*

**"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 persons with *CONFIRMED* COVID-19 infection. **Except for rare situations, a test-based strategy is not recommended to determine when to allow personnel to return to work. A test-based strategy could, for example, be considered for some healthcare personnel (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the person being infectious for more than 20 days.**

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

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens)

## III. Health Care Personnel, Critical Infrastructure Personnel, and Essential Services Workers

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:

•Pre-Screen: Employers should measure the employee's temperature and assess symptoms prior to them starting work. Ideally, temperature checks should happen before the individual enters the facility.

•Regular Monitoring: As long as the employee doesn't have a temperature or symptoms, they should self-monitor under the supervision of their employer's occupational health program (if available).

•Wear a Mask: The employee should wear a face mask at all times while in the workplace for 14 days after last exposure. Employers can issue facemasks or can approve employees' supplied cloth face coverings in the event of shortages.

•Social Distance: The employee should maintain 6 feet and practice social distancing as work duties permit in the workplace.

•Disinfect and Clean Workspaces: Clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment routinely.

Employees returning from isolation should still report temperature and absence of symptoms each day prior to starting work. Facilities should have employees wear an appropriate face covering (i.e. medical facemask for direct patient care workers or cloth face covering for all others) while at work for the 14 days following fever resolution and improvement in symptoms. If the employee develops even mild symptoms consistent with COVID-19, they must cease work activities, wear a face covering (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 healthcare personnel employees returning following isolation discontinuation from high-risk patient care areas, including but not limited to: NICU, units housing immunosuppressed non-COVID-19 patients, or other fragile patient populations. Returning healthcare personnel may be directed to care for COVID-positive patients.

## IV. Discontinuation of Home Isolation/Return to Work for ASYMPTOMATIC Persons with CONFIRMED COVID-19

Individuals with *CONFIRMED* COVID-19 who have **not** had any symptoms may discontinue home isolation when at least 10 days have passed since the date of their first positive COVID-19 diagnostic test **and** have had no subsequent illness. For healthcare personnel who are severely immunocompromised, however, (but who were asymptomatic throughout their infection), individuals may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test. If there has been illness subsequent to the first positive test, the individual must proceed according to the guidance for symptomatic persons with confirmed COVID-19 above.

## V. Immunity, Vaccination Status, Re-testing, and Re-infection

The immune response, including duration of immunity, to COVID-19 infection is not yet completely understood. It is not yet known whether similar immune protection will be observed for persons infected with COVID-19 as seen with MERS-CoV and SARS-CoV-1 infections.

While mRNA COVID-19 vaccines have demonstrated high efficacy at preventing severe and symptomatic COVID-19, there is currently limited (but growing) information on how much the vaccines might reduce transmission and how long protection lasts. The efficacy of the vaccines against currently circulating SARS-CoV-2 variants is good, however efficacy against future/emerging variants is not known. At this time, vaccinated persons should continue to follow current guidance to protect themselves and others, including wearing a mask, staying at least 6 feet away from others, avoiding crowds, avoiding poorly ventilated spaces, covering coughs and sneezes, washing hands often, following CDC travel guidance, and following any applicable workplace or school guidance, including guidance related to personal protective equipment use or SARS-CoV-2 testing.

**However, vaccinated persons with an exposure to someone with suspected or confirmed COVID-19 are not required to quarantine if they meet both of the following criteria[†]:**

- Are fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine)
- Have remained asymptomatic since the current COVID-19 exposure

Persons who do not meet both of the above criteria should continue to follow current quarantine guidance after close contact exposure to someone with suspected or confirmed COVID-19.

As an exception to the above guidance no longer requiring quarantine for fully vaccinated persons, vaccinated inpatients and residents in healthcare settings (including long-term care facilities) and fully vaccinated residents of non-healthcare congregate settings (e.g., correctional and detention facilities, group homes) should continue to quarantine following an exposure to someone with suspected or confirmed COVID-19; outpatients in healthcare settings should be cared for using appropriate Transmission-Based Precautions.

[†]In situations of exceptional or sustained close contact with persons infected with COVID-19 where social distancing inherently cannot be maintained (e.g. household contacts), decisions regarding quarantine should be made in consultation with the individual's employer or employee health, and may consider further consultation with medical or public health professionals. Risk of transmission despite vaccination should be weighed against the benefits of allowing an individual to continue to work.

For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection. In addition, quarantine is not recommended in the event of close contact with an infected person.

For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended. Quarantine may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.

## VI. Definition of Severely Immunocompromised

For the purposes of this guidance, the following definition was created to more generally address healthcare personnel 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 healthcare personnel 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.

- Ultimately, the degree of immunocompromise for healthcare personnel is determined by the treating provider, and preventive actions are tailored to each individual and situation.