

“CDC’s Return to Work Healthcare Guidance” (2021), downloaded from <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html> on April 27, 2021.



## COVID-19

# Return to Work Criteria for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)

Updated Feb. 16, 2021 [Print](#)

CDC guidance for SARS-CoV-2 infection may be adapted by state and local health departments to respond to rapidly changing local circumstances.

This guidance provides information for making decisions about return to work for healthcare personnel (HCP) with SARS-CoV-2 infection using a symptom-based strategy. See [history of updates](#)

## Summary of Recent Changes

Updates as of February 16, 2021 

As of February 16, 2021

Changes to more closely align guidance with updates to the [Decision Memo](#):

- HCP who are severely immunocompromised, could remain infectious more than 20 days after symptom onset. Consultation with infectious diseases specialists is recommended; use of a test-based strategy for determining when these HCP may return to work could be considered.

## Key Points

- The symptom-based strategy (described below) depends on: the time period since symptoms first appeared and whether symptoms are improving; whether HCP are immunocompromised; the severity of their illness
- A test-based strategy is not recommended ([except as noted below](#))

## Introduction

This guidance is for occupational health programs and public health officials making decisions about return to work for HCP with confirmed SARS-CoV-2 infection, or who have suspected SARS-CoV-2 infection (e.g., developed [symptoms of COVID-19](#)) but were never tested for SARS-CoV-2.

HCP 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 person for SARS-CoV-2 is indicated, [negative results](#) from at least one FDA Emergency Use Authorized 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, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists. If the second test is positive, consultation with an infectious diseases expert should be considered to resolve the discrepant results.

For HCP who were suspected of having COVID-19 and had it ruled out, then return to work decisions should be based on their other suspected or confirmed diagnoses.

**Decisions about return to work for HCP with SARS-CoV-2 infection** should be made in the context of local circumstances. In general, a symptom-based strategy should be used as described below. The time period used depends on the HCP's severity of illness and if they are severely immunocompromised.

**A test-based strategy is not recommended (except as noted below) because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.**

**Asymptomatic HCP with potential exposure:** For guidance about assessment of risk and application of work restrictions for asymptomatic HCP with potential exposure to patients, visitors, or other HCP with confirmed COVID-19, refer to the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#).

## Symptom-based strategy for return to work.

**HCP with mild to moderate illness who are *not* severely immunocompromised:**

- At least 10 days have passed *since symptoms first appeared and*
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

**HCP who were asymptomatic throughout their infection and are *not* severely immunocompromised:**

- At least 10 days have passed since the date of their first positive viral diagnostic test.

**HCP with severe to critical illness or who are severely immunocompromised:**

- At least 10 days and up to 20 days have passed *since symptoms first appeared and*
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- Consider consultation with infection control experts

HCP who are **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. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when these HCP may return to work could be considered.

As described in the [Decision Memo](#), an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. Recovery of replication-competent virus has been reported in severely immunocompromised patients beyond 20 days, and as long as 143 days, after a positive SARS-CoV-2 test result.

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 in determining the appropriate duration for specific HCP. For example, HCP with characteristics of severe illness may be most appropriately managed with at least 15 days before return to work. Use of a test-based strategy, in consultation with infectious disease specialists, for determining when HCP who are severely immunocompromised may return to work could be considered.

## SARS-CoV-2 Illness Severity Criteria

(Adapted from the [NIH COVID-19 Treatment Guidelines](#) [↗](#))

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 when HCP with SARS-CoV-2 infection may return to work, 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 HCP 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 (SpO<sub>2</sub>) ≥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.

## Severely immunocompromised definition

The studies used to inform this guidance did not clearly define “severely immunocompromised”. For the purposes of this guidance, CDC used the following definition:

- Some conditions, such as being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, 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 HCP 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 HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

## When to use a test-based strategy

In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the [Decision Memo](#), many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

The criteria for the test-based strategy are:

### HCP who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **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. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

### HCP who are not symptomatic:

- 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. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#).

# Return to Work Practices and Work Restrictions

- After returning to work, HCP should self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen.

## Mitigating HCP staffing shortages

Maintaining appropriate staffing in healthcare 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. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including 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.

## History of Updates

As of August 10, 2020

Changes to more closely align guidance with [Decision Memo](#):

- For HCP with [severe to critical illness](#) or who are severely immunocompromised<sup>1</sup>, the recommended duration for work exclusion was changed to at least 10 days and up to 20 days after symptom onset.
- Recommendation to consider consultation with infection control experts.
- Added example applying disease severity in determining duration before return to work.
- Added hematopoietic stem cell or solid organ transplant to severely immunocompromised conditions.

Last Updated Feb. 16, 2021