SUMMARY OF UPDATES:

The following sections comply with NYSDOH and CDC guidance

1. All staff are required to report all suspected and confirmed SARS-CoV-2 infections to OHS.

2. In most circumstances, asymptomatic HCP with higher-risk exposures **do not** require work restriction regardless of vaccination status.

3. HCP with higher risk exposure must have a series of 3 viral tests: 1st test not earlier than 24 hours after the exposure and, if negative again 48 hours after the first negative test and, if negative again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 and no work restrictions.

4. HCP has COVID-19 -like symptoms; prioritize testing, if negative test HCP most likely does not have COVID-19.

5. HCP has SARS-CoV-2 infection; is asymptomatic and not immunocompromised, then Isolate for 7 days, viral test negative 48 hours prior to returning to work.

6. HCP has SARS-CoV-2 infection; mild to moderate illness and moderate to severe immuno-suppression, then Isolate for 7 days, viral test negative 48 hours prior to returning to work, fever free at least 24 hours prior to returning and symptoms have improved.

7. HCP has SARS-CoV-2 infection; severe to critical illness and **not** moderate to severe immunosuppression, then Isolate for at least 10 days and up to 20 days, viral test negative 48 hours prior to returning to work, fever free at least 24 hours prior to returning and symptoms have improved.

8. HCP has SARS-CoV-2 infection; severe to critical illness and moderate to severe immunosuppression, then Isolate for at least 10 days and up to 20 days, viral test negative 48 hours prior to returning to work, fever free at least 24 hours prior to returning and symptoms have improved. Use test-based strategy to determine work restriction and consult an infectious diseases specialist or other expert.

9. Due to challenges in interpreting the results, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those HCP who have recovered from SARS-CoV-2 in the prior 31-90 days; however, an antigen test instead of NAAT (PCR) is recommended.

10. 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).

11. Effective 5/12/2023, 2 doses monovalent Pfizer and Moderna Vaccines are being replaced by 1 dose of bivalent Pfizer and Moderna. This constitutes fully vaccinated status for the HCP.

Purpose	To provide guidance on return to work criteria after COVID-19 infection or exposure.
Scope	All New York City Health + Hospitals Personnel
Process	**Evaluating Healthcare Personnel with Symptoms of SARS-CoV-2 (COVID-19) Infection**

Symptom Status	Vaccination Status	Return to Work Criteria
Mild symptoms	ANY	• Prioritize viral testing with nucleic acid or antigen detection assays • When testing a person with COVID-19 like symptoms, negative results from at least one viral test indicates that the person most likely does not an active SARS-CoV-2 infection at the time the sample was collected.

Return to Work Criteria for HCP with SARS-CoV-2 Infection

- The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influence by symptom severity and presence of immunocompromising conditions.
- After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from OHS if symptoms 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.
- Either a NAAT/PCR (molecular) or antigen test maybe used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later (day 7) *
- The exact Criteria that determine which HCP will shed replication-competent virus for longer periods are not known.

Process	Symptom Status	Immunocompromising Conditions	Return to Work Criteria
	Asymptomatic	Not Moderate to Severe	• At least 7 days have passed since the date of their first positive if a negative viral test*is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7)
	Mild to moderate Illness	Moderate to Severe	• At least 7 days have passed since symptoms first appeared in a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **and** • Symptoms have improved (e.g., cough, shortness of breath)
	Severe to critical Illness	Not Moderate to Severe	• At least 10 days and up to 20 days have passed since symptoms first appeared, and • At least 24 hours have passed since the fever without the use of fever -reducing medications, and • Symptoms have improved (e.g., cough, shortness of breath) • The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction

Process

Test-based strategy for use with HCP that are moderately to severely immunocompromised

- Moderately to severely immunocompromised HCP 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
- Use of the test-based strategy (as described) and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work
- **HCP who are symptomatic could return to work after the following criteria are met:**
  - 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 2 consecutive respiratory specimens collected 48 hours apart (total of two negative specimens') tested using antigen test or NAAT(PCR).
- **HCP who are asymptomatic could return to work after the following criteria are met:**
  - Results are negative from at **2 consecutive respiratory specimens** collected 48 hours apart (**total of two negative specimens**) tested using an antigen test or NAAT (PCR).

Return to Work Criteria for HCP Who Were Exposed to Individuals with Confirmed SARS-CoV-2 Infection

Higher-risk exposures are classified as HCP who had prolonged, close contact, with a patient, visitor, or HCP with confirmed SARS+CoV-2 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask for facemask)
- HCP was not wearing eye protection if the person with SAR-CoV-2 infections was not wearing aa cloth mask of facemask
- HCP was not wearing all recommended PPE (i.e., Gown, Gloves, Eye protection, Respirator) while present in the room for an aerosol-generating procedure.

Process	Following a higher-risk exposure, the HCP **must**:
	• Have a series of 3 viral test for SARS-CoV-2 infection.
	  ○ Testing is recommended immediately but not earlier than 24 hours after the exposure and, if negative, again 48 hours after the first negative test and, if negative again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
	  ○ Due to challenges in interpreting the result, testing is generally not recommended for **asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days**. Testing should be considered for those HCP who have recovered from SARS-CoV-2 in the prior 31-90 days; however, an antigen test instead of NAAT (PCR) is recommended. This is because some people may remain NAAT positive but not infectious during this period.
	• Follow all recommended infection prevention and control practices, including wearing a well-fitting source control, monitoring themselves for fever, or symptoms consistent with COVID-19 and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.
	• Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their OHS department for further instructions.

	Work restriction **is not required** for most asymptomatic HCP following a higher risk exposure, regardless of vaccination status, Examples of when work restriction should be considered include: • HCP is unable to be tested or wear source control as recommended for 10 days following their exposure; • HCP is moderately to severely immunocompromised; • HCP cares for or works on a unit with patients who are moderately to severely immunocompromised; • HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.
	If work restriction is recommended, HCP can return to work after either of the following time periods: • HCP can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described for asymptomatic HCP following higher-risk exposure is negative. • If viral testing is not performed, HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

Process	• Follow all recommended infection prevention and control practices, including wearing a well-fitting source control, monitoring themselves for fever, or symptoms consistent with COVID-19 and not reporting to work when ill or if testing positive for SARS-CoV-2 infection. • Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their OHS department for further instructions.
	Determining the time period when the patient, visitor or HCP with confirmed SARS-CoV- 2 infection could have been infectious; • For HCP with confirmed SARs-CoV-2 infection who develop symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions. • For HCP with confirmed SARs-CoV-2 infection who are asymptomatic, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic hcp with SARS-CoV-2 infection may have been exposed could help inform the period when they are infectious. • If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the HCP meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
	HCP with Travel or Community Exposures
	• HCP must contact their OHS department for guidance on work restrictions. • In general, HCPs who have had prolonged, close contact with someone in the community with SARS-CoV-2 (example, household contacts) should be managed as described for higher-risk occupational exposures above. • 100% remote symptomatic workers should contact their OHS department for guidance on work restrictions.

Definitions	**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. • Other factors, such as end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about need for work restriction if the HCP had close contact with someone with SARS-CoV-2 infection. However, people in this category should still consider continuing to practice physical distancing and use of source control while in a healthcare facility, even if they have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC. • Ultimately, the degree of immunocompromise for the HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.
	SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines)	**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 (SpO2) ≥94% on room air at sea level.

		Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <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 (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
		Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
		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.
	Exposure	HCP: Prolonged ("prolonged" refers to a cumulative time period of 15 minutes during a 24-hour period) close (within 6 feet) contact with a patient, visitor or HCP with confirmed COVID-19. In addition, HCP was not wearing a respirator or face mask or HCP was not wearing protective eyewear if the person with COVID-19 was not wearing a facemask or HCP not wearing all recommended PPE during an aerosol generating procedure with a patient with confirmed COVID-19 or HCP was deemed to have had an

		exposure (including proximate contact) by a local health department.
	Higher-risk exposures	High risk exposures generally involve the HCP's eyes, nose and mouth to material containing SARS-CoV-2, particularly if the HCP were present is in the room for an aerosol-generating procedure. HCP has had prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infections
	Other exposures	Exposures not classified as high risk include having body contact with the patient (e.g., rolling the patient) *without gown or gloves* particularly if hand hygiene is not performed and the HCP touches their eyes, mouth or nose. 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 of lower the level of risk; interventions, including restrictions from work, can be adjusted based on the estimated risk for transmission.
	Prolonged close contact	HCP who has prolonged close contact (within 6 feet for a cumulative total of 15 minutes over 24 hours) to someone with SARS-CoV-2 infection who is not using PPE correctly, not wearing a well-fitting mask whether the HCP and/or the individual with SARS-CoV-2 infection are fully vaccinated or any duration should be considered prolonged if the exposure occurred during the performance an aerosol-generating procedure.
	Fully vaccinated	≥2 weeks after they have received the second dose in a Monovalent 2- dose series (Pfizer-BioNTech or Moderna or a WHO approved vaccine) or ≥2 weeks after they have received a 1-dose of Johnson and Johnson (J&J)/Janssen or 1-dose of Bivalent Pfizer or Moderna vaccine.
	Partially vaccinated	Received 1 dose of a 2-dose series (Pfizer-BioNTech or Moderna or a WHO approved vaccine).
References	CDC: Potential Exposure at Work: https://www.cdc.gov/coronavirus/2019- ncov/hcp/guidance-risk-assesment-hcp.html Interim Guidance for Managing Healthcare personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, September 23,2022. Healthcare worker vaccine mandate guidance, NYSDOH, May 24, 2023.	

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