**Quarantine** is for individuals who may have been exposed to someone who is COVID-19 positive but are not exhibiting any symptoms and have not tested positive. Individuals who are in quarantine should stay in place for 14 days.

**Isolation** is for individuals who have either tested positive for COVID-19 or who are exhibiting symptoms of COVID-19 (including fever, chills, shaking chills, muscle pain, headache, sore throat, or new loss of taste or smell) and have been told by a provider that they have, or probably have, COVID-19, even in the absence of a test.

<table>
<tr><th>Worker Type</th><th>Quarantine for 14 days when…</th><th>Isolate when…</th><th>End Isolation and Return to work when…</th></tr>
<tr><td>Health Care Workers<br><br>First Responders<br><br>Essential Workers</td><td rowspan="2">As of May 4, 2020, the CDC is not recommending that these workers self-quarantine after an exposure if they are not experiencing COVID-19 symptoms. All workers should wear appropriate PPE, and self-monitor for symptoms.</td><td rowspan="3">You have tested positive for COVID-19<br>OR<br>you have symptoms of COVID-19</td><td rowspan="3">Symptomatic<br><br>1. Symptom-based strategy<br>• At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and<br>• Improvement in respiratory symptoms (e.g., cough, shortness of breath); and,<br>• At least 10 days have passed since symptoms first appeared.<br><br>2. Test-based strategy:<br>• Resolution of fever without the use of fever-reducing medications and<br>• Improvement in respiratory symptoms (e.g., cough, shortness of breath), and<br>• Negative results of two consecutive respiratory specimens collected ≥24 hours apart<br><br>Asymptomatic<br><br>1. Time-based strategy: At least 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.<br><br>2. Test-based strategy: Negative results of two consecutive respiratory specimens collected ≥24 hours apart<br><br>*A positive test does not necessarily correlate with the person's ability to transmit the disease</td></tr>
<tr><td>All Other Workers</td><td>You have been exposed to someone with COVID-19<br>BUT<br>you don't have symptoms</td></tr>
</table>

## Healthcare Personnel (HCP):

## Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19

### *Ending Isolation/Return to Work Guidance*

Symptomatic HCP with suspected or confirmed COVID-19

1. **Symptom-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 10 days have passed *since symptoms first appeared*

2. **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 COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).
   - **Note: there have been reports of prolonged detection of RNA without direct correlation to viral culture.**

HCP with laboratory-confirmed COVID-19 who have not had any symptoms

1. **Time-based strategy**. Exclude 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 they develop symptoms, then the *symptom-based* or *test-based strategy* should be used.
   - Note: because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

2. **Test-based strategy.** Exclude from work until:

   - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).
   - Note: because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

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 healthcare 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.
- HCP should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- HCP should self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

***Employers should not require a COVID-19 test result or a healthcare provider's note for employees who are sick to validate their illness, qualify for sick leave, or to return to work.***

## *At-work Exposure*

*Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19)*

### *I. Definitions:*

***Self-monitoring*** means HCP should monitor themselves for fever by taking their temperature twice a day and remain alert for symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise). Anyone on self-monitoring should be provided a plan for whom to contact if they develop fever or respiratory symptoms during the self-monitoring period to determine whether medical evaluation is needed.

***Active monitoring*** means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever or symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise*. For HCP with high- or medium-risk exposures, CDC recommends this communication occurs at least once each day. The mode of communication can be determined by the state or local public health authority and may include telephone calls or any electronic or internet-based means of communication.

For HCP, active monitoring can be delegated by the health department to the HCP's healthcare facility occupational health or infection control program, if both the health department and the facility are in agreement. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

***Self-Monitoring with delegated supervision*** in a healthcare setting means HCP perform self-monitoring with oversight by their healthcare facility's occupational health or infection control program in coordination with the health department of jurisdiction, if both the health department and the facility are in agreement. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, a facility may consider having HCP report temperature and absence of symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

Occupational health or infection control personnel should establish points of contact between the organization, the self-monitoring personnel, and the local or state health departments of authority in the location where self-monitoring personnel will be during the self-monitoring period. This communication should result in agreement on a plan for medical evaluation of personnel who develop fever or symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise) during the self-monitoring period. The plan should include instructions for notifying occupational health and the local public health authority, and transportation arrangements to a designated hospital, if medically necessary, with advance notice if fever or symptoms of COVID-19 occur. The supervising organization should remain in contact with HCP through the self-monitoring period to manage self-monitoring activities and provide timely and appropriate follow-up if symptoms occur in a HCP. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

***Close contact*** for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters) of a person with COVID-19 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); or b) having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

Data are limited for definitions of close contact. Factors for consideration include the duration of exposure (e.g., longer exposure time likely increases exposure risk), clinical symptoms of the patient (e.g., coughing likely increases exposure

risk) and whether the patient was wearing a cloth face covering or facemask (which helps block respiratory secretions from contaminating others and the environment), PPE used by personnel, and whether aerosol generating procedures were performed.

Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it is reasonable to consider an exposure greater than a few minutes as a prolonged exposure. Brief interactions are less likely to result in transmission; however, clinical symptoms of the patient and type of interaction (e.g., did the patient cough directly into the face of the HCP) remain important. Recommendations will be updated as more information becomes available.

Risk stratification can be made in consultation with public health authorities. Examples of brief interactions include: briefly entering the patient room without having direct contact with the patient or their secretions/excretions, brief conversation at a triage desk with a patient who was not wearing a cloth face covering or facemask. See Table 1 for more detailed information.

***Healthcare Personnel***: For the purposes of this document, 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; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

## *II. Defining Exposure Risk Category*

While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit, and urine, might put HCP at risk of COVID-19.

Table 1 describes possible scenarios that can be used to assist with risk assessment. These scenarios do not cover all potential exposure scenarios and should not replace an individual assessment of risk for the purpose of clinical decision making or individualized public health management. Any public health decisions that place restrictions on an individual's or group's movements or impose specific monitoring requirements should be based on an assessment of risk for the individual or group. Healthcare facilities, in consultation with public health authorities should use the concepts outlined in this guidance along with clinical judgement to assign risk and determine need for work restrictions.

For this guidance *high-risk* exposures refer to HCP who have had prolonged close contact with patients with COVID-19 (beginning 48 hours before onset of symptoms) who were not wearing a cloth face covering or facemask while HCP nose and mouth were exposed to material 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 (beginning 48 hours before onset of symptoms) 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 (beginning 48 hours before onset of symptoms) who were wearing a cloth face covering or facemask while HCP nose and mouth were exposed to material 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, HCP 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 AGP had not been performed, they would have been considered *low-risk*. See Table 1 for additional examples.

*Low-risk* exposures generally refer to brief interactions with patients with COVID-19 (beginning 48 hours before onset of symptoms) or prolonged close contact with patients (beginning 48 hours before onset of symptoms) who were wearing

a cloth face covering or facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection in addition to a facemask or respirator would further lower the risk of exposure.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision.

HCP with no direct patient contact and no entry into active patient management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have *no identifiable risk*).

*Currently, this guidance applies to HCP with potential exposure in a healthcare setting to patients with confirmed COVID-19. However, HCP exposures could involve a person under investigation (PUI) who is awaiting testing. Implementation of monitoring and work restrictions described in this guidance could be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to a PUI should be maintained and HCP should be encouraged to perform self- monitoring while awaiting test results. If the results will be delayed more than 72 hours or the patient is positive for COVID-19, then the monitoring and work restrictions described in this document should be followed.*

**Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease 2019 (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations**

*The highest risk exposure category that applies to each person should be used to guide monitoring and work restrictions.*

Note: While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into our assessment of risk.

**Table 1: Epidemiologic Risk Classification[1] for Asymptomatic Healthcare Personnel Following Exposure to Patients with 2019 Novel Coronavirus (2019-nCoV) Infection or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations**

| Epidemiologic risk factors | Exposure category | Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)* | Work Restrictions for Asymptomatic HCP |
|---|---|---|---|
| Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who **was wearing a cloth face covering or facemask** (i.e., source control) | | | |
| *HCP PPE: None* | Medium | Active | Exclude from work for 14 days after last exposure |
| *HCP PPE: Not wearing a facemask or respirator* | Medium | Active | Exclude from work for 14 days after last exposure |
| *HCP PPE: Not wearing eye protection* | Low | Self with delegated supervision | None |
| *HCP PPE: Not wearing gown or gloves*[a] | Low | Self with delegated supervision | None |
| *HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)* | Low | Self with delegated supervision | None |
| Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who **was not wearing a cloth face covering or facemask** (i.e., no source control) | | | |
| *HCP PPE: None* | High | Active | Exclude from work for 14 days after last exposure |
| *HCP PPE: Not wearing a facemask or respirator* | High | Active | Exclude from work for 14 days after last exposure |
| *HCP PPE: Not wearing eye protection*[b] | Medium | Active | Exclude from work for 14 days after last exposure |
| *HCP PPE: Not wearing gown or gloves*[a,b] | Low | Self with delegated supervision | None |
| *HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)*[b] | Low | Self with delegated supervision | None |

HCP=healthcare personnel; PPE=personal protective equipment

[a]The risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient)

[b]The risk category for these rows would be elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP 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.

*Additional Scenarios:*

- Refer to the footnotes above for scenarios that would elevate the risk level for exposed HCP. For example, HCP 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.
- Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision.
- HCP not using all recommended PPE who have only brief interactions with a patient regardless of whether patient was wearing a cloth face covering or facemask are considered low-risk. Examples of brief interactions include: brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or the patient's secretions/excretions; entering the patient room immediately after the patient was discharged.
- HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room are considered to have no identifiable risk.

## *III. Recommendations for Monitoring Based on COVID-19 Exposure Risk*

**HCP in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work**

1. ***High- or Medium-risk* Exposure Category**
   HCP 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$100.0°F or subjective fever) OR symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise) they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.

2. ***Low-risk* Exposure Category**
   HCP in the *low-risk* category should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic HCP in this category are not restricted from work. They should check their temperature twice daily and remain alert for symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise). They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or symptoms consistent with COVID-19 they may report to work. If they develop fever (measured temperature $\geq$ 100.0 °F or subjective fever) OR symptoms consistent with COVID-19 they should immediately self-isolate (separate themselves from others) and notify their local or state public health

authority or healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.

On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, facilities could consider having HCP 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.

3. **HCP who Adhere to All Recommended Infection Prevention and Control Practices**
   Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

4. ***No Identifiable risk* Exposure Category**
   HCP in the *no identifiable risk* category do not require monitoring or restriction from work.

5. **Community or travel-associated exposures**
   HCP with community- or travel-associated exposures to COVID-19 should inform their facility's occupational health program that they have had a community or travel-associated exposure. Decisions about restriction from work should be made in consultation with the occupational health program. HCP who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.