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## Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure

The information contained herein supersedes previous guidance related to returning to work after SARS-CoV-2 infection or exposure in healthcare settings.

### Background

Due to concerns about increased transmissibility of the SARS-CoV-2 [Omicron variant](#), this guidance is being updated to enhance protection for healthcare personnel (HCP), patients, and visitors, and to address concerns about potential impacts on the healthcare system given a surge of SARS-CoV-2 infections. **These updates will be refined as additional information becomes available.** Summary of changes:

- Updated recommendations regarding when HCP with SARS-CoV-2 infection could return to work based on the level of staffing shortages present at a healthcare facility.
- Added options that would allow asymptomatic HCP with a higher-risk exposure who have not received all COVID-19 vaccine doses, including booster dose, as recommended by [CDC](#) to return to work prior to the previously recommended 14-day post-exposure period of work restriction, as long as they do not develop symptoms or test positive for SARS-CoV-2.

### 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. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. Either an antigen test or nucleic acid amplification test (NAAT) can be used. Conventional return-to-work criteria are as follows:

Symptomatic HCP	<ul style="list-style-type: none"> <li>• At least 7 days have passed <i>since symptoms first appeared</i> if HCP had a negative test within 48 hours prior to returning to work (or 10 days have passed if testing is not performed or if HCP had a positive test at day 5-7), <b>and</b></li> <li>• At least 24 hours have passed <i>since last fever</i> without the use of fever-reducing medications, <b>and</b></li> </ul>
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	<ul style="list-style-type: none"> <li>Symptoms (e.g., cough, shortness of breath) have improved.</li> </ul>
Asymptomatic HCP	At least 7 days have passed <i>since the date of the HCP's first positive test</i> if HCP had a negative test within 48 hours prior to returning to work (or 10 days if testing is not performed or a positive test at day 5–7).

Additional considerations for HCP with [severe illness](#) or who are [moderately to severely immunocompromised](#) can be found in [CDC Return to Work Guidance](#).

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

This guidance does not supplant the need for HCP with even mild symptoms of COVID-19 to be prioritized for viral testing. HCP who become symptomatic or test positive for COVID-19 should follow Return to Work Criteria for HCP with SARS-CoV-2 Infection.

### Recommended Work Restrictions for HCP Based on Vaccination Status and Type of Exposure

Exposure Category	Boosted HCP	Non-Boosted HCP (even if within 90 days of previous infection)
<a href="#">Higher-risk</a>	No work restrictions with negative tests on days 2 and 5–7 after exposure	10 days OR 7 days with negative test
<a href="#">Lower-risk</a>	No work restrictions or testing	

HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.

Other circumstances when work restriction might be recommended include:

- When HCP are [moderately to severely immunocompromised](#).
- When directed by public health authorities (e.g., during an outbreak in which SARS-CoV-2 infections are identified among HCP who have received all COVID-19 vaccine doses, including booster dose, as recommended by [CDC](#)). In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to restriction from work of HCP with higher-risk exposures who have received all COVID-19 vaccine doses, including booster dose, as recommended by CDC. In these and other circumstances, the jurisdiction's public health authority may recommend additional precautions.

## Contingency & Crisis Strategies to Mitigate Staffing Shortages

Healthcare facilities may employ contingency and crisis-level strategies to address staffing shortages. Contingency and crisis-level strategies and considerations for their implementation are detailed in CDC's [Strategies to Mitigate Healthcare Personnel Staffing Shortage Guidance](#). Definitions of contingency and crisis strategies are provided below.

Healthcare facilities should employ a sequential approach, noting that escalating to contingency or crisis tiers increases the risk of spread in healthcare settings if not implemented with broad infection control measures. Such measures include universal use of well-fitting masks in healthcare settings, frequent environmental disinfection, ventilation, hand hygiene, and physical distancing in the workplace. Special attention should be given to infection prevention in areas (e.g., nursing stations, meal and break rooms) where spread among healthcare workers is most likely to occur.

Once facilities move to implement contingency- or crisis-level strategies, it is strongly recommended that they 1) educate all HCP in the universal use of [well-fitting masks](#) at all times when in the facility; and 2) ensure that these masks are readily accessible to HCP for voluntary use. N95 (NIOSH-approved) filtering facepiece respirators are the best option for well-fitting protection, but KN95s or medical procedure masks that are [adjusted to provide a better fit to the face](#) are also an option. Oregon OSHA does not require fit testing or a medical evaluation for the voluntary use of an N95 filtering facepiece respirator. However, facilities must ensure that when HCP use any respirator it is done in accordance with Oregon OSHA's requirements and [workplace advisory memo 10.1.2021](#). Additional information on Oregon OSHA's COVID-19 rule, and their respiratory protection standard can be found at [osha.oregon.gov](http://osha.oregon.gov).

A decision to implement crisis-level strategies should be communicated to state and local public health authorities to inquire whether state-level resources have been exhausted.

### Definitions

- **Healthcare setting:** Refers to any place where health care, including physical or behavioral health care, is delivered and includes, but is not limited to any health care facility or agency licensed under ORS 441 and 443, such as hospitals, ambulatory surgical centers, birthing centers, special inpatient-care facilities, long-term acute-care facilities, inpatient rehabilitation facilities, inpatient hospice facilities, nursing homes and assisted-living facilities, home health care, hospice, in-home care, vehicles or temporary sites where health care is delivered (e.g., mobile clinics, ambulances), and outpatient facilities, such as dialysis centers, physician offices, dental clinics, urgent-care centers, counseling offices, offices that provide complementary and alternative medicine such as acupuncture, homeopathy, naturopathy, chiropractic and osteopathic medicine, and other specialty centers.

**Healthcare personnel (HCP):** Refers to paid and unpaid persons serving in health care settings who have the potential for direct or indirect exposure to patients or potentially infectious materials, including body substances (e.g., blood, tissue and specific body fluids) and includes, but is not limited to, emergency medical service (EMS) personnel, nurses, nursing assistants, home health care personnel, hospice personnel, in-home

caregivers, physicians, dentists, dental hygienists, technicians, therapists, phlebotomists, pharmacists, traditional health workers, counselors, students and trainees, contractual staff not employed by the health care setting and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing and volunteer personnel).

- **Prolonged close contact:** Refers to proximity within 6 feet of an individual with SARS-CoV-2 infection for a cumulative total of 15 minutes or more over a 24-hour period.
- **Conventional strategy:** Standard practices recommended by public health.
- **Contingency-level strategy:** Practices employed to address staffing shortages that pose an impending threat to clinical or essential operations and which, if not implemented, would lead to substandard clinical care within 48 to 72 hours.
- **Crisis-level strategy:** Practices employed to address staffing shortages that pose an immediate threat to clinical or essential operations and that are expected to lead to loss of life due to insufficient clinical care despite implementation of contingency strategies.

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