MANAGING HEALTH CARE PERSONNEL
WITH SARS-CoV-2 INFECTION & EXPOSURE
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Michigan.gov/Coronavirus

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, the Centers for Disease Control and Prevention (CDC) has updated guidance to enhance protection for health care personnel (HCP), patients, and visitors, and to address the impact of staffing shortages on the health care system given a surge of SARS-CoV-2 infections.

Evaluating HCP with Symptoms of SARS-CoV-2 Infection

HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays; ensure that SARS-CoV-2 testing is performed with a test that is capable of detecting SARS-CoV-2 even with currently circulating variants in the United States.

If after evaluation for COVID-19 another diagnosis is suspected or confirmed, return to work decisions should be based on HCP's other suspected or confirmed diagnoses.

Managing HCP with SARS-CoV-2 Infection

Work Restrictions for HCP with SARS-CoV-2 Infection

Vaccination Status	Conventional	Contingency	Crisis
Up to Date and Not Up to Date	10 days OR 7 days with negative test†, if asymptomatic or mildly symptomatic (with improving symptoms)	5 days with/without negative test, if asymptomatic or mildly symptomatic (with improving symptoms)	No work restriction, with prioritization considerations (e.g., asymptomatic or mildly symptomatic). Facilities should utilize all available strategies to minimize risk of transmission if these standards are adopted.

†Negative test result within 48 hours before returning to work

Definitions: **Up to date** means a person has received all recommended doses in their primary series COVID-19 vaccine, and a booster dose when eligible.

Follow the CDC Return to Work Criteria after SARS-CoV-2 Infection:

Return to work criteria is determined by severity of illness and if the HCP is immunocompromised. This guidance applies to:

- HCP with mild to moderate illness who are *not* moderately to severely immunocompromised.
- HCP with severe to critical illness and are *not* moderately to severely immunocompromised.
- HCP who were asymptomatic and are *not* moderately to severely immunocompromised.

Test-based Strategy

HCP who are moderately to 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.

For HCP who are moderately to severely immunocompromised, use of a test-based strategy 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.

Managing HCP with SARS-CoV-2 Exposures

Work Restrictions for Asymptomatic HCP with Exposures

In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction if they are up to date with all recommended COVID-19 doses and do not develop symptoms or test positive for SARS-CoV-2. The duration of protection offered by booster doses of vaccine and their effect on emerging variants are not clear; additional updates will be provided as more information becomes available.

Vaccination Status	Conventional	Contingency	Crisis
Up to Date	No work restrictions, with negative test on days 1 ‡ and 5-7	No work restrictions	No work restrictions
Not Up to Date	10 days or 7 days with negative test	No work restriction with negative tests on days 1‡, 2, 3, & 5-7 (if shortage of tests prioritize Day 1 to 2 and 5-7)	No work restrictions (test if possible)

‡For calculating day of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0

Definitions: **Up to date** means a person has received all recommended doses in their primary series COVID-19 vaccine, and a booster dose when eligible.

Strategies to Mitigate Staffing Shortages

Maintaining appropriate staffing in health care facilities is essential to providing a safe work environment for HCP and for safe patient care. Maximizing interventions to protect HCP, patients, and visitors are critical at all times, including when considering strategies to address staffing shortages. CDCs mitigation strategies offer a continuum of options for addressing staffing shortages. Contingency, followed by crisis capacity, strategies augment conventional strategies and are **meant to be considered and implemented sequentially** (i.e., implementing contingency strategies before crisis strategies).

The Michigan Guidelines for Implementation of Crisis Standards of Care and Ethical Allocation of Scarce Medical Resources and Services during Emergencies and Disasters provide guidance to decision-makers throughout the state of Michigan to assist in making choices about resource and service allocation and prioritization during situations of scarcity that may arise during public health emergencies.

As SARS-CoV-2 variants cause health care capacity surge, health care systems may mitigate personnel staffing shortages by following CDC Strategies to Mitigate Healthcare Personnel Staffing Shortages for exposed workers:

Conventional staffing strategy: No anticipated or current staffing shortage.

- Breaks down risk of exposure, personal protective equipment used, and vaccination status of health care worker.
- HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. In general, 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.

Contingency staffing strategy: Anticipated staffing shortages.

- When staffing shortages are anticipated, health care facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem.

Crisis staffing strategy: Facility is working within a staffing shortage.

- When contingency strategy is unable to meet criteria for safe patient care. Implement crisis capacity as a last resort. Crisis staffing strategies should be implemented for the minimum time and to the minimum extent necessary

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For additional information, see Interim Guidance for Managing Healthcare Personnel with SARSCoV-2 Infection or Exposure to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).