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Confirmed or Suspected COVID-19 Disease Clearance Guidance (Release from Isolation/Return to Work)

The Kentucky Department for Public Health (KDPH), consistent with CDC guidance, recommends a symptom-based strategy to determine resolution of COVID-19 clinical disease and likely infectivity. This guidance represents KDPH's best expert judgment on this date and will continue to evolve as understanding of COVID-19 improves.

Individuals with either laboratory-confirmed or clinically suspected COVID-19 who have *mild to moderate, symptomatic* COVID-19 should be excluded from work (remain in isolation) until **all** the following criteria are met:

- 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.

Individuals with laboratory-confirmed or clinically suspected COVID-19 with *severe or critical* illness or who are severely immunocompromised, should be excluded from work (remain in isolation) until **all** the following criteria are met:

- At least 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.

Individuals with laboratory-confirmed COVID-19 who have not had any symptoms and are not severely immunocompromised should be excluded from work (remain in isolation) until 10 days have passed since the date of their first positive COVID-19 viral diagnostic test (i.e., date the sample was obtained from patient, not reported by lab).

Individuals with COVID-19 who have not had any symptoms and are severely immunocompromised should be excluded from work (remain in isolation) until 20 days have passed since the date of their first positive COVID-19 viral diagnostic test.

Residents with laboratory-confirmed COVID-19 or symptomatic, clinically suspected COVID-19 returning to confined population environments or congregate settings (e.g., long-term care facilities, behavioral health hospitals, prisons, etc.)

[CDC guidance dated July 22, 2020](#) compellingly asserts that retesting individuals to determine absence of disease is not supported by current evidence. KDPH concurs with CDC and advises use of a time-based strategy. At this time, there is insufficient medical evidence to support the requirement for repeat diagnostic testing as a condition for the return of a COVID-19 patient to a congregate setting. Because of the unique concerns of the potential for transmission of infection and the vulnerability of residents in congregate settings, however, KDPH recommends that these residents remain in COVID-19 transmission-based precautions until **all** the following criteria are met:

- At least 14 days have passed *since symptoms first appeared (if mild or moderate) or at least 20 days have passed since symptoms first appeared (if severe or critical)*; **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.

Additional Considerations:

1. Testing for COVID-19 after recovery from illness and release from isolation.

- For persons previously diagnosed with COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset (date of testing, if asymptomatic) for the initial COVID-19 infection. Likewise, quarantine is not recommended in the event of close contact with an infected person during that period.
- For persons who develop new symptoms consistent with COVID-19 during the 3 months after initial infection, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended. Isolation may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.

2. Work in healthcare settings for those exposed but not yet symptomatic or not yet testing positive for COVID-19:

- Healthcare providers and first responders, who are exposed but not symptomatic, should quarantine using [CDC guidance](#) and as adopted by [KDPH](#). If they are critical to healthcare work and a staffing crisis would ensue without them, they may be permitted to work, but required to wear a surgical mask at all times when on the job for 14 days after exposure. Whether quarantining or working, they should practice social distancing principles, actively monitor for symptoms, and self-isolate the moment any symptoms (e.g., elevated temperature, sore throat, cough or other respiratory symptoms, loss of smell or taste) arise. Healthcare workers who were exposed and develop symptoms should be tested immediately.

3. Return to Work Practices and Work Restrictions for healthcare professionals who have tested positive for COVID-19:

After returning to work, employees should:

- Wear a surgical facemask for source control at all times while in a healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. A surgical facemask instead of a cloth face covering should be used by these employees for source control during this time period both at work and in public. After this time period and for the duration of this pandemic, employees should revert to the universal source control policy at their facility while at work and KDPH guidance for the general public when in other settings.
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset.
- Self-monitor for signs & symptoms of illness and seek re-evaluation from occupational health or their healthcare provider if fever and/or respiratory symptoms recur or worsen.
- Know that surgical facemask for source control does not replace the need to wear an N95 or higher-level respirator (and 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.)

4. Work in non-healthcare settings for those exposed but not yet symptomatic or not yet testing positive for COVID-19:

- Workers in non-healthcare settings, who are exposed but not symptomatic, are to quarantine using [CDC guidance](#) and as adopted by [KDPH](#). They should actively monitor for symptoms and should be tested immediately if any signs/symptoms consistent with COVID-19 develop.

5. Return to Work Practices and Work Restrictions for non-healthcare workers who have tested positive for COVID-19:

Upon release from isolation and return to work, employees should:

- Wear a cloth facemask for source control at work at all times when in proximity to others and in confined spaces with others (including break areas), until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. After this time period and for the duration of this pandemic, employees should revert to the universal source control policy at their facility while at work and to KDPH guidance for the general public when in other settings.
- Be restricted from contact with severely immunocompromised people (e.g., coworkers, public) until symptoms completely resolve or 14 days after illness onset, whichever is longer.
- Self-monitor for signs & symptoms of illness and seek re-evaluation from occupational health or their healthcare provider if fever and/or respiratory symptoms recur or worsen.

Definitions

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 duration of Transmission-Based Precautions, 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 patient at any point in their clinical course should be used when determining the duration of Transmission-Based Precautions.

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, $SpO_2 <94\%$ 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_2/FiO_2) <300 mmHg, or lung infiltrates $>50\%$.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

Severely Immunocompromised: Is not clearly defined in the [CDC guidance](#) or in the studies providing the basis for the guidance.

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count <200 , combined primary immunodeficiency disorder, and receipt of prednisone >20 mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.