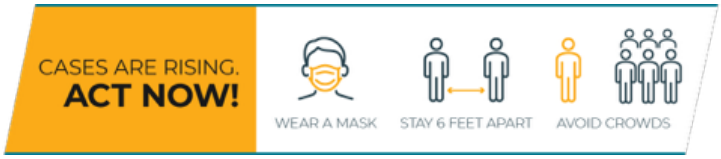

Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2

Updated Dec. 14, 2020 Print

Note: This document is intended to provide guidance on the appropriate use of testing among healthcare personnel and does not dictate the determination of payment decisions or insurance coverage of such testing, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency.

Summary of Recent Changes

Updates as of December 14, 2020

- Added recommendation, mirroring testing guidance for community exposures, to test asymptomatic healthcare personnel (HCP) with higher risk exposures to SARS-CoV-2 while at work.
- Added considerations for performing expanded screening of asymptomatic HCP without known or suspected exposure to SARS-CoV-2

This document provides a summary of considerations and current Centers for Disease Control and Prevention (CDC) recommendations regarding testing healthcare personnel (HCP) for SARS-CoV-2. This document does not apply to individuals who do not meet the definition of HCP as defined below. The CDC recommendations for SARS-CoV-2 testing have been developed based on what is currently known about COVID-19 and are subject to change as additional information becomes available.

Testing of HCP can be considered in four situations:

1. Testing HCP with signs or symptoms consistent with COVID-19
2. Testing asymptomatic HCP with known or suspected exposure to SARS-CoV-2
3. Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 as

part of expanded screening

4. Testing HCP who have been diagnosed with SARS-CoV-2 infection to determine when they are no longer infectious

Testing should be prioritized for HCP with signs and symptoms consistent with COVID-19 and HCP with high-risk exposures to SARS-CoV-2 as described below.

Viral tests (authorized nucleic acid or antigen detection assays) are recommended to diagnose acute infection. Testing practices should aim for rapid turnaround times (i.e., less than 24 hours) in order to facilitate effective interventions. Testing the same individual more than once in a 24-hour period is not recommended.

HCP undergoing testing should receive clear information on:

- the purpose of the test
- the reliability of the test and any limitations associated with the test
- who will pay for the test and how the test will be performed
- how to interpret results and any next steps related to the results
- who will receive the results
- how the results may be used
- any consequences for declining testing

Recommended practices to prevent occupational exposure to SARS-CoV-2 are described in the Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Guidance for assessing HCP exposure risk and determining the need for work restrictions is available in the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19

Testing HCP with signs or symptoms consistent with COVID-19

HCP with signs or symptoms of COVID-19 should be prioritized for SARS-CoV-2 testing. Because HCP often have extensive and close contact to vulnerable populations, even mild signs or symptoms (e.g., sore throat) of possible COVID-19 should prompt consideration for testing. Clinicians should use their judgment to determine if HCP have signs or symptoms compatible with COVID-19 and whether HCP should be tested.

CDC recommends using authorized nucleic acid or antigen detection assays that have received an FDA Emergency Use Authorization to test persons with symptoms when there is a concern of potential COVID-19. Tests should be used in accordance with the authorized labeling. Providers should be familiar with the tests' performance characteristics and limitations.

Testing asymptomatic HCP with known or suspected exposure to SARS-CoV-2

As part of community contact tracing efforts, viral testing is recommended for HCP who have had close contact with persons with SARS-CoV-2 infection in the community (including household contacts).

Exposures encountered by HCP are unlike those that might occur the community, and trained HCP generally use personal protective equipment (PPE) to reduce the risk of transmission. Because of this, assessment of HCP exposures should be performed as described in the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. Due to their often extensive and close contact with vulnerable individuals, this guidance recommends managing occupationally exposed HCP conservatively:

- For certain exposures believed to pose a higher risk for transmission, CDC recommends that exposed HCP be excluded from work for 14 days following the exposure.
- For other, lower risk exposures, HCP may continue to work; however, CDC recommends screening for symptoms prior to starting work each day and using source control measures as described in CDC's infection control recommendations.

Similar to exposures in the community, testing initially and, if negative, again about 5-7 days post exposure could be considered for HCP with higher-risk exposures to more quickly identify pre-symptomatic or asymptomatic HCP who could contribute to SARS-CoV-2 transmission in the community. However, HCP with higher-risk exposures should still be excluded from work for 14 days, even if testing during this period does not identify SARS-CoV-2 infection. However, facilities with staffing shortages can refer to CDC's staffing mitigation guidance, which describes considerations for allowing HCP with higher-risk exposures to work during their 14-day post-exposure period including options for shortening the quarantine period. For HCP with lower-risk exposures, CDC continues to recommend symptom screening and source control measures while at work. As resources allow, facilities could consider testing HCP with lower-risk exposures for SARS-CoV-2 as described above.

Facilities that elect to perform post-exposure testing of HCP should be aware that testing is logistically challenging and has limitations. For example, testing only identifies the presence of virus at the time of the test. It is possible that HCP can test negative because they are very early in their infection when their sample is collected. In such situations, they could test positive later and transmit the virus to others; for this reason, repeat testing about 5-7 days after the exposure should be considered. Also, when there is SARS-CoV-2 transmission occurring in the community, positive tests in HCP do not necessarily indicate transmission due to exposures in the workplace.

If testing of exposed HCP is instituted, test results should be available rapidly (i.e., within 24 hours), and there should be a clear plan to respond to results. The Occupational Safety and Health Administration's rules for Recording and Reporting Occupational Injuries and Illness (29 CFR part 1904) should be consulted regarding requirements for certain employers to make and keep records of work- related cases of COVID-19.

In **nursing homes**, expanded viral testing of all HCP is recommended in response to an outbreak in the facility. Testing of all residents is also recommended in this situation. See the Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents for more information. An outbreak is defined as a new SARS-CoV-2 infection in any HCP or any nursing home-onset SARS-CoV-2 infection in a resident. Expanded viral testing includes initial testing of all HCP followed by repeat testing of all previously negative HCP, generally between every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. Expanded viral testing of HCP could also be considered in other healthcare settings in some situations (e.g., when multiple instances of SARS-CoV-2 transmission are identified among patients or HCP).

Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 as part of expanded screening

CDC continues to recommend that testing be prioritized for HCP with symptoms consistent with COVID-19 and for asymptomatic HCP with known or suspected exposure to SARS-CoV-2 as described above.

Currently, testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 is recommended for HCP working in **nursing homes** .

Testing asymptomatic HCP who do not work in nursing homes can be considered if resources are available; general guidance is available in the CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2. When contemplating such expanded testing in other healthcare settings, the following should be considered:

- Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 is most valuable when it is repeated frequently, especially if testing is conducted with a test with a lower sensitivity. Testing less frequently than once per week increases the risk of missing HCP who are infected between scheduled tests. Additional considerations about frequency and scope of testing are described in the CDC Guidance for Expanded Screening Testing to Reduce Silent Spread of SARS-CoV-2.
- Facilities and health departments should consider the resources necessary to sustain these efforts before implementation. This might include an increased demand for confirmatory testing as false positives will occur, particularly when testing people who are less likely to be infected, such as HCP with no known exposure.
- Testing might be most impactful when conducted on HCP who have regular close contact (within 6 feet) with large numbers of patients or who regularly care for persons with risk factors or medical conditions that increase the risk of severe illness.

Testing to determine when HCP with SARS-CoV-2 infection are no longer infectious

A test-based strategy, which requires serial tests and improvement in symptoms, could be considered to allow HCP with SARS-CoV-2 to return to work earlier than the symptom-based strategy. However, in most cases, the test-based strategy results in prolonged work exclusion of HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. A test-based strategy could also be considered for some HCP (e.g., severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days. In all other circumstances, the symptom-based strategy should be used to determine when HCP may return to work.

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 health personnel, physicians, technicians, therapists, phlebotomists, pharmacists, 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.

Healthcare settings refers to places where healthcare is delivered and include, but are not limited to, acute care facilities, long-term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities such as dialysis centers, physician offices, and others.

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