

Policy: EMS Provider Quarantine and Return to Work Related to SARS-CoV-2/COVID-19 Exposure and/or Illness

Purpose: To assist with assessment of risk, monitoring, and work restriction decisions for EMS providers with potential or confirmed exposure to SARS-CoV-2/COVID-19. This is based closely on the CDC recommendations and OSF Healthcare System policies and procedures.

Definitions within this Policy:

Self-monitoring:

EMS provider should monitor themselves for fever by taking their temperature twice a day and remain alert for respiratory symptoms (e.g., cough, shortness of breath, sore throat). Anyone on self-monitoring should contact their direct supervisor if they develop fever or respiratory symptoms during the self-monitoring period to determine whether medical evaluation is needed.

Active monitoring: State or local public health authority assumes responsibility for establishing regular communication with potentially exposed EMS provider to assess for the presence of fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat). For EMS providers with *high-* or *medium-risk* exposures, the 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 EMS providers, active monitoring can be delegated by the health department to occupational health, EMS office, or infection control program, if both the health department and the facility are in agreement.

*Note: inter-jurisdictional coordination will be needed if EMS provider lives in a different local health jurisdiction than where the EMS agency is located.

Self-Monitoring with delegated supervision: EMS provider will perform self-monitoring with oversight by their occupational health or infection control program in coordination with the health department of jurisdiction, if both the health department and the agency are in agreement. On days the EMS provider is scheduled to work, the EMS agency could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, an EMS agency may consider having the EMS provider 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 agency, the self-monitoring personnel, and the local or state health departments of authority in the location where self-monitoring provider will be during the self-monitoring period. This communication should result in agreement on a plan for medical evaluation of providers who develop fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat) 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 respiratory symptoms occur. The EMS agency should remain in contact with EMS provider through the self-monitoring period to manage self-monitoring activities and provide timely and appropriate follow-up if symptoms occur in an EMS provider.

*Note: inter-jurisdictional coordination will be needed if EMS provider lives in a different local health jurisdiction than where the EMS agency is located.

Close contact:

- a) Being within approximately 6 feet (2 meters), of a person with SARS-CoV-2/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)
- 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).

*Note: Per the CDC, current data is insufficient to define the duration of time that constitutes a prolonged exposure. 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 EMS provider) remain important.

High Risk Exposure: EMS providers who have had prolonged close contact with patients with COVID-19 who were not wearing a facemask while the EMS provider's nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room during aerosolizing procedures 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 when the EMS providers' eyes, nose, or mouth were not protected, is also considered *high-risk*.

Medium Risk Exposure: EMS providers who had prolonged close contact with patients with COVID-19 who were wearing a facemask while the EMS provider's 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, EMS providers who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosolizing procedure would be considered to have a medium-risk exposure. If an aerosolizing procedure had not been performed, they would have been considered *low-risk*.

Low-risk Exposure:

Brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while the EMS providers were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure.

Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with suspected or confirmed 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 COVID-19 patient who was wearing a 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 COVID-19 patient who was not wearing a 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

Source: CDC 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 (COVID-19)

^aThe 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).

^bThe 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.

Recommendations for Confirmed Exposure to Suspected/Confirmed COVID-19 Patients:

If EMS providers in any of the risk exposure categories develop signs or symptoms compatible with COVID-19, they must contact their established point of contact (public health authorities or their occupational health program) for medical evaluation prior to returning to work (See Return to Work Section).

1. *High- and Medium-risk Exposure Category*

Active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any fever (measured temperature $\geq 100.0^{\circ}\text{F}/38^{\circ}\text{C}$ or subjective fever) **OR** respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat) they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and EMS agency promptly so that they can coordinate consultation and referral for further evaluation.

2. *Low-risk Exposure Category*

Self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic EMS providers in this category are not restricted from work. They should check their temperature twice daily and remain alert for respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat). They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or respiratory symptoms they may report to work. If they develop fever (measured temperature $\geq 100.0^{\circ}\text{F}/38^{\circ}\text{C}$ or subjective fever) **OR** respiratory symptoms they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority or EMS agency promptly so that they can coordinate consultation and referral for further evaluation. On days HCP are scheduled to work, provider will wear a surgical mask at all times until 14 days after last potential exposure.

3. *Community or travel-associated exposures*

EMS providers who have traveled to a country with a Level 3 travel advisory as defined by the CDC should remain off work for 14 days after arriving back from the area and will be required to track and report their symptoms. For community exposures refer to chart below.

Risk Categories for Exposures Associated with Contact Investigations of Laboratory-confirmed Cases

Risk Level	Exposures Identified through Contact Investigation
High	Living in the same household as, being an intimate partner of, or providing care in a non-healthcare setting (such as a home) for a person with symptomatic laboratory-confirmed COVID-19 infection <i>without using recommended precautions</i> for home care and home isolation
Medium (assumes no exposures in the high-risk category)	<ul style="list-style-type: none"> • Close contact with a person with symptomatic laboratory-confirmed COVID-19 • On an aircraft, being seated within 6 feet (two meters) of a traveler with symptomatic laboratory-confirmed COVID-19 infection; this distance correlates approximately with 2 seats in each direction • Living in the same household as, an intimate partner of, or caring for a person in a non-healthcare setting (such as a home) to a person with symptomatic laboratory-confirmed COVID-19 infection <i>while consistently using recommended precautions</i> for home care and home isolation
Low (assumes no exposures in the high-risk category)	Being in the same indoor environment (e.g., a classroom, a hospital waiting room) as a person with symptomatic laboratory-confirmed COVID-19 for a prolonged period of time but not meeting the definition of close contact

Return to Work Criteria for EMS Provider with Confirmed or Suspected COVID-19:

1. *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 molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens).

2. *Non-test-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 7 days have passed *since symptoms first appeared*

If the EMS provider was never tested for COVID-19 but 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, the EMS provider should:

- Wear a facemask at all times while on duty until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Source: Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)