

5 Key Strategies For Successfully Navigating the Respiratory Virus Season in Dentistry



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Presented by:
Linda Harvey, MS, RDH
and
Mary Govoni, MBA, RDH, CDA



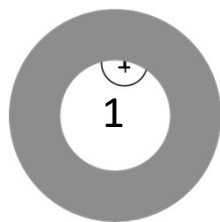
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Support for this program is provided by:

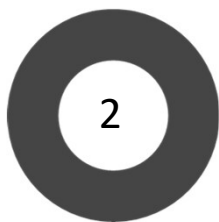


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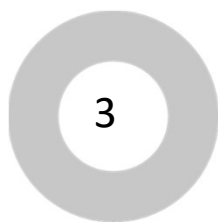
5 Key Strategies:



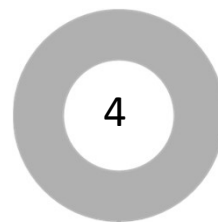
Stay current on health data.



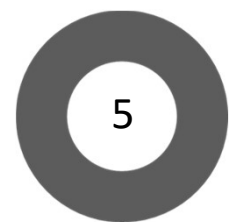
Practice Prevention.



Maximize ventilation.

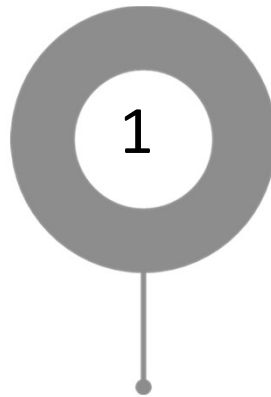


Screen patients.



Don't come to work sick!

4



Stay current on health data.

5

Stay Current

- **Verifiable Information sources**
 - CDC and WHO
 - State and county public health departments
 - Dental and medical organizations
 - Peer-reviewed professional journals
- **Not-so-reliable sources**
 - Social media
 - Internet sites that are:
 - Not related to the public health system
 - Not connected to professional organizations



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The New York Times

As Covid-19 Continues to Spread, So Does Misinformation About It

Doctors are exasperated by the persistence of false and misleading claims about the virus.

“It’s easy to forget that health misinformation, including about Covid, can still contribute to people not getting vaccinated or creating stigmas,” said Megan Marrelli, the editorial director of Meedan, a nonprofit focused on digital literacy and information access. “We know for a fact that health misinformation contributes to the spread of real-world disease.”

<https://www.nytimes.com/2022/12/28/technology/covid-misinformation-online.html>

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About CIDRAP

Real-world infectious disease experts

The Center for Infectious Disease Research and Policy (CIDRAP: "SID-wrap") is a global leader in addressing public health preparedness and emerging infectious disease response. Founded in 2001, CIDRAP is part of the **Research and Innovation Office** at the **University of Minnesota**.

CIDRAP works to prevent illness and death from targeted infectious disease threats through research and the translation of scientific information into real-world, practical applications, policies, and solutions.

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<https://www.cidrap.umn.edu/about-cidrap>

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NEWS TOPICS & PROJECTS PODCASTS NEWSLETTERS ABOUT SUPPORT

US respiratory illness levels still high but showing some signs of reprieve

Linia Schatzberg, Today at 3:36 p.m.
Topics: COVID-19, Influenza, General, Respiratory Syncytial Virus (RSV)



Illnesses from three main respiratory viruses remain high across the nation, but, for a second week, some indicators that the Centers for Disease Control and Prevention (CDC) tracks, such as hospitalizations and SARS-CoV-2 wastewater levels, showed declines.

In its latest updates for **COVID-19**, flu, and respiratory syncytial virus (RSV), the CDC said rapid increases seen in the weeks leading up to the winter holidays have slowed, with decreases noted for COVID-19 and continuing declines in RSV activity in some regions. Overall, flu activity shows stable or declining trends, but the CDC said it is closely watching for a second spike that sometimes occurs after the winter holidays.

Hospital occupancy, including intensive care unit capacity, remains stable for all causes, including COVID and flu.



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Articles

Long-term outcomes following hospital admission for COVID-19 versus seasonal influenza: a cohort study

Yun-Kei Tsang, Chai, T, *et al.*

Summary

Background Previous comparative analyses of people admitted to hospital for COVID-19 versus influenza evaluated the risk of death, hospital readmission, and a narrow set of health outcomes up to 6 months following infection. We aimed to do a comparative evaluation of both acute and long-term risks and burdens of a comprehensive set of health outcomes following hospital admission for COVID-19 or seasonal influenza.

Methods For this cohort study we used the health care databases of the US Department of Veterans Affairs to analyse data from 81288 participants admitted to hospital for COVID-19 between March 1, 2020, and June 30, 2022, and 19 985 participants admitted to hospital for seasonal influenza between Oct 1, 2015, and Feb 28, 2019. Participants were followed up for up to 18 months to comparatively evaluate risks and burdens of death, a pre-specified set of 94 individual health outcomes, ten organ systems, overall burden across all organ systems, readmission, and admission to intensive care. Inverse probability weighting was used to balance the baseline characteristics. Cox and Poisson models were used to generate estimates of risk on both the relative scale and absolute scale as the event rate and disability-adjusted life-years (DALYs) per 100 persons.

Findings Over 18 months of follow-up, compared to seasonal influenza, the COVID-19 group had an increased risk of death (hazard ratio [HR] 1.51 [95% CI 1.45-1.58], corresponding to an excess death rate of 8.42 [95% CI 7.55-9.44] per 100 persons in the COVID-19 group versus the influenza group. Comparative analyses of 94 pre-specified health outcomes showed that COVID-19 had an increased risk of 68-78% (64 of 94) pre-specified health outcomes; seasonal influenza was associated with an increased risk of 6-47% (six of 94) pre-specified health outcomes, including three out of four pre-specified pulmonary outcomes. Analyses of organ systems showed that COVID-19 had a higher risk across all organ systems except for the pulmonary system, the risk of which was higher in seasonal influenza. The cumulative rates of adverse health outcomes across all organ systems were 615.18 (95% CI 605.15-624.83) per 100 persons in COVID-19 and 516.96 (527.38-544.96) per 100 persons in seasonal influenza, corresponding to an excess rate of 78-72 (95% CI 66-151-154) per 100 persons in COVID-19. The total number of DALYs across all organ systems were 247.43 (95% CI 231.38-231.59) per 100 persons in the COVID-19 group and 242.64 (236.75, 247.67) per 100 persons in the seasonal influenza group, corresponding to 47.40 (95% CI 37.15-52.96) higher DALYs per 100 persons in COVID-19. Decomposition analyses showed that in both COVID-19 and seasonal influenza, there was a higher burden of health loss in the post-acute than the acute phase, and comparatively, except for the pulmonary system, COVID-19 had a higher burden of health loss across all other organ systems than seasonal influenza in both the acute and post-acute phase. Compared to seasonal influenza, COVID-19 also had an increased risk of hospital readmission (excess rate 28.50 [95% CI 16.39-24.86] per 100 persons) and admission to intensive care (excess rate 9.23 [6.48-11.82] per 100 persons). The findings were consistent in analyses comparatively evaluating risks in seasonal influenza versus COVID-19 by individuals' respective vaccination status and in those admitted to hospital during the pre-delta, delta, and omicron eras.

Interpretation Although rates of death and adverse health outcomes following hospital admission for either seasonal influenza or COVID-19 are high, this comparative analysis shows that hospital admission for COVID-19 was associated with higher long-term risks of death and adverse health outcomes in nearly every organ system (except for the pulmonary system) and significant cumulative excess DALYs than hospital admission for seasonal influenza. The substantial cumulative burden of health loss in both groups calls for greater prevention of hospital admission for these two viruses and for greater attention to the care needs of people with long-term health effects due to either seasonal influenza or SARS-CoV-2 infection.

Funding US Department of Veterans Affairs.

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Introduction analysis of people admitted to hospital for COVID-19 versus influenza evaluated the risk of death, hospital readmission, and a narrow set of health outcomes up to 6 months following infection. These studies showed increased risk of mortality and adverse health outcomes in multiple organ systems. Previous comparative

Lancet Infect Dis 2023; 23(12): 1611-1622
Published Online December 14, 2023
https://doi.org/10.1016/S1473-3099(23)00684-9
See Article Online
https://www.thelancet.com/action/showPdf?pii=S1473-3099(23)00684-9
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[https://www.thelancet.com/action/showPdf?pii=S1473-3099\(23\)00684-9](https://www.thelancet.com/action/showPdf?pii=S1473-3099(23)00684-9)

www.thelancet.com/infection Published online December 14, 2023 | [https://doi.org/10.1016/S1473-3099\(23\)00684-9](https://doi.org/10.1016/S1473-3099(23)00684-9)

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Current Public Health Data

What is going on with COVID-19, RSV, and Influenza???

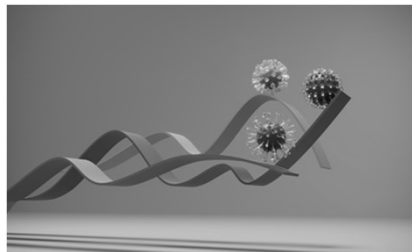


CDC Centers for Disease Control and Prevention
CDC 24/7. Saving Lives, Protecting People™

CORONAVIRUS DISEASE 2019 (COVID-19)

CDC.gov/COVID-19

January 19, 2024
Amount of Respiratory Illness is Elevated or Increasing in Most Areas of the Country



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CDC Centers for Disease Control and Prevention
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Emergency Preparedness and Response

Resources for Emergency Health Professionals > Health Alert Network (HAN) > HAN Archive > 2023

- Health Alert Network (HAN)
 - HAN Jurisdictions
 - HAN Message Types
 - Sign Up for HAN Updates
 - HAN Archive
 - 2023
 - HAN00503
 - HAN00502
 - HAN00501

Urgent Need to Increase Immunization Coverage for Influenza, COVID-19, and RSV and Use of Authorized/Approved Therapeutics in the Setting of Increased Respiratory Disease Activity During the 2023 - 2024 Winter Season

Print

HAN HEALTH ALERT NETWORK

This is an official **CDC** HEALTH ADVISORY

<https://emergency.cdc.gov/han/2023/han00503.asp>

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COVID-19

Severity Indicators

Hospitalizations >

Hospital Admissions

35,801
(December 31 to January 6, 2024)

Trend in Hospital Admissions
+3.2% in most recent week

Nov 18, 2023 Jan 6, 2024

Deaths >

% of All Deaths in U.S. Due to COVID-19

4.0%
(December 31 to January 6, 2024)

Trend in % COVID-19 Deaths
+14.3% in most recent week

Nov 18, 2023 Jan 6, 2024

Source: CDC COVID Data Tracker

<https://covid.cdc.gov/covid-data-tracker/#datatracker-home>

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New Look for Local COVID Data



COVID-19 County Check

Find hospital admission levels and prevention steps by county. Data updated weekly.

Select a Location (all fields required)

State County

<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>

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COVID-19 hospital admissions levels in U.S. by county
Based on new COVID-19 hospital admissions per 100,000 population

	Total	Percent	% Change
≥ 20.0	252	7.82%	-1.68%
10.0 - 19.9	1226	38.05%	0.93%
<10.0	1744	54.13%	0.96%

Time Period: New COVID-19 hospital admissions per 100,000 population (7-day total) are calculated using data from the MMWR week (Sun-Sat) ending January 6, 2024.

Reported COVID-19 New Hospital Admissions Rate per 100,000 Population in the Past Week, by County - United States



https://covid.cdc.gov/covid-data-tracker/#maps_new-admissions-rate-county

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COVID-19 County Check

Find hospital admission levels and prevention steps by county. Data updated weekly.

Select a Location (all fields required)

Florida Duval County

< Start Over

Low

In **Duval County, Florida**, the COVID-19 hospital admission level is **Low**.

COVID-19 County Check

Find hospital admission levels and prevention steps by county. Data updated weekly.

Select a Location (all fields required)

Illinois Cook County

< Start Over

Medium

In **Cook County, Illinois**, the COVID-19 hospital admission level is **Medium**.

COVID-19 County Check

Find hospital admission levels and prevention steps by county. Data updated weekly.

Select a Location (all fields required)

Massachusetts Suffolk County

< Start Over

Medium

In **Suffolk County, Massachusetts**, the COVID-19 hospital admission level is **Medium**.

<https://covid.cdc.gov/covid-data-tracker/#datatracker-home>

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People are still dying from COVID-19.

Provisional Weekly COVID-19 Deaths in the United States

JAN. 7, 2023 – DEC. 30, 2023

*Highest number of weekly deaths during the pandemic were 25,974 the week ending Jan. 9, 2021

SOURCE: NATIONAL CENTER FOR HEALTH STATISTICS, NATIONAL VITAL STATISTICS SURVEILLANCE

Provisional Weekly COVID-19 Deaths in the United States- Jan. 7, 2023 - Dec. 30, 2023
National Center for Health Statistics, National Vital Statistics Surveillance

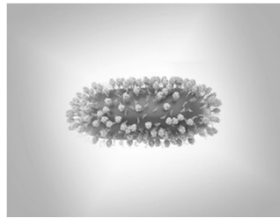
<https://abcnews.go.com/Health/1500-americans-dying-covid-week/story?id=106237143>

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Respiratory Syncytial Virus (RSV)

What is RSV?

- Common respiratory virus that usually causes mild, cold-like symptoms.
- Per the CDC: Most people recover in a week or two, but RSV can be serious.
- Infants and older adults are more likely to develop severe RSV and need hospitalization. If you are age 60 or older, a vaccine is available to protect you from severe RSV.



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Symptoms of RSV

People infected with RSV usually show symptoms within 4-6 days after getting infected. Symptoms usually include:

- Runny nose
- Decrease in appetite
- Coughing
- Sneezing
- Fever
- Wheezing



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RSV Resources

Respiratory Syncytial Virus Infection (RSV)

[Español](#) [Print](#)



Respiratory syncytial (sin-SISH-uh) virus, or RSV, is a **common respiratory virus that usually causes mild, cold-like symptoms**. Most people recover in a week or two, but RSV can be serious. Infants and older adults are more likely to develop severe RSV and need hospitalization. If you are age 60 or older, a vaccine is available to protect you from severe RSV. Talk to your healthcare provider to see if it's right for you. If you are pregnant, you can get an RSV vaccine between 32–36 weeks of pregnancy to protect your infant after birth, or a preventive antibody can be given to your baby after birth.

Symptoms & Care



Know the symptoms to look for and how to care for people with RSV.

[Symptoms & Care](#)

Preventing RSV



Preventive options help protect certain groups at high risk of severe RSV.

[Preventing RSV](#)

Transmission



Help protect yourself and your loved ones from RSV infection.

[Transmission](#)

<https://www.cdc.gov/rsv/index.html>

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RSV Concerns

- Can lead to more severe infections such as bronchitis and pneumonia
- Most common cause of bronchitis and pneumonia in children younger than 1 year of age
- Most at-risk populations
 - Infants
 - Young Children
 - Older adults



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<https://www.cdc.gov/rsv/index.html>

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RSV Vaccines

[https://w](https://www.cdc.gov/rsv/downloads/RSV-in-Infants-and-Young-Children.pdf)

RSV in Infants and Young Children

Respiratory syncytial virus, or RSV, is a common virus that affects the lungs. RSV season starts in the fall and peaks in the winter in most regions of the U.S.

Protect your young child from RSV. There are two options to protect babies from severe RSV. Most babies only need one, not both.

RSV vaccine given during pregnancy:

- Protection passed to baby during pregnancy
- Recommended when 32-36 weeks pregnant
- Usually given during September-January

RSV antibody given to the baby:

- Directly provides protection to baby
- Recommended for babies younger than 8 months
- Usually given during October-March

A dose of RSV antibody is also recommended for the following children between the ages of 8 and 19 months entering their second RSV season:

- Children who have chronic lung disease from being born prematurely
- Children who are severely immunocompromised
- Children with cystic fibrosis who have severe disease
- American Indian and Alaska Native children

Talk to your healthcare provider to determine which option is best for you and your baby.



RSV is the LEADING CAUSE of infant hospitalization in the U.S.

www.cdc.gov/rsv

Older Adults Are at High Risk for Severe RSV Illness

Respiratory Syncytial Virus, or RSV, is a common virus that affects the lungs and breathing passages

- ✓ RSV vaccine is available to adults 60 and over
- ✓ It can PROTECT against severe illness
- ✓ Talk to your doctor to see if vaccination is right for you

RSV can be dangerous for older adults

Adults who are 60 years or older are at highest risk, especially:


- Adults who have chronic heart or lung disease
- Adults who have weakened immune systems

RSV can lead to serious conditions

- Pneumonia (infection of the lungs)
- Hospitalization
- More severe symptoms for people with chronic obstructive pulmonary disease (COPD)
- More severe symptoms for people with congestive heart failure

Everyday preventive measures help protect against respiratory viruses

- Wash hands often
- Avoid close contact with sick people
- Avoid touching your face with unwashed hands
- Cover coughs and sneezes
- Clean frequently touched surfaces
- Stay home when sick



EACH YEAR RSV causes serious illness in older adults

60,000–160,000 hospitalizations

6,000–10,000 deaths

www.cdc.gov/rsv

<https://www.cdc.gov/rsv/downloads/RSV-in-Infants-and-Young-Children.pdf>

<https://www.cdc.gov/rsv/factsheet-older-adults.pdf>

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RSV Prevention

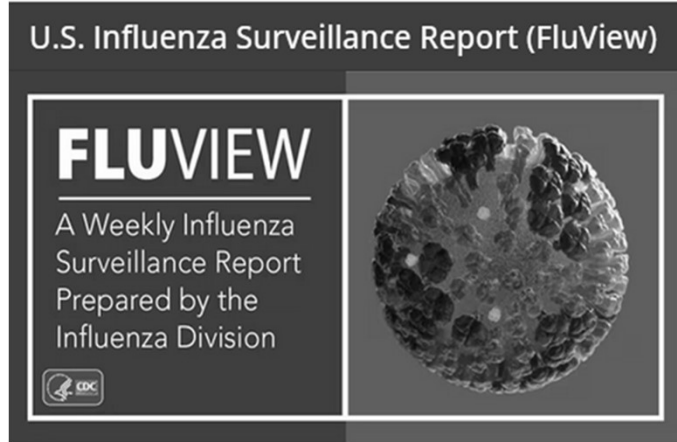
RSV immunizations are recommended only for these groups:

- **Adults ages 60 and older:** [Two RSV vaccines](#) (Arexvy by GSK and Abrysvo by Pfizer) have been licensed by FDA and recommended by CDC for adults ages 60 and older, using shared clinical decision-making.
- **Pregnant women:** [One RSV vaccine](#) (Abrysvo by Pfizer) has been licensed and recommended during weeks 32 through 36 of pregnancy to protect infants.
- **Infants and some young children:** An [RSV preventive antibody](#) has been licensed and recommended for infants and some young children.

<https://www.cdc.gov/rsv/about/prevention.html>

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Seasonal Influenza



<https://www.cdc.gov/flu/weekly/fluviewinteractive.htm>

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Current Seasonal Flu Trends

	Week 1	Data Cumulative since October 1, 2023 (Week 40)
Influenza A	11,942 (79.5%)	98,983 (80.2%)
Influenza B	3,076 (20.5%)	24,415 (19.8%)

<https://www.cdc.gov/respiratory-viruses/whats-new/index.html>

Illness Severity Update:

- Rates of COVID-19- and influenza-associated hospitalizations remain elevated throughout most of the country; however, slight decreases have been reported in recent weeks. Hospitalization rates for RSV remain elevated in all surveillance sites.
- Nationally, the percent of viral respiratory deaths among all deaths for the week ending January 6 increased from 4.5% to 5.2%, which was driven mainly by an increase in deaths associated with COVID-19.

Reported on Friday, January 19th, 2024.

<https://www.cdc.gov/respiratory-viruses/data-research/dashboard/illness-severity.html>

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Current Seasonal Flu Trends

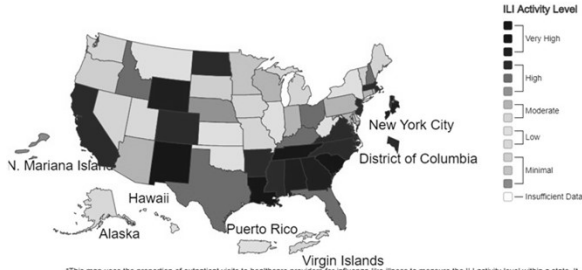


A Weekly Influenza Surveillance Report Prepared by the Influenza Division

Outpatient Respiratory Illness Activity Map Determined by Data Reported to ILINet

This system monitors visits for respiratory illness that includes fever plus a cough or sore throat, also referred to as ILI, not laboratory confirmed influenza and may capture patient visits due to other respiratory pathogens that cause similar symptoms.

2023-24 Influenza Season Week 2 ending Jan 13, 2024



<https://www.cdc.gov/flu/weekly/index.htm#ILINet>

*This map uses the proportion of outpatient visits to healthcare providers for influenza-like illness to measure the ILI activity level within a state; it does not, however, measure the extent of geographic spread of flu within a state. Therefore, outbreaks occurring in a single city could cause the state to display high activity levels.

*Data collected in ILINet may disproportionately represent certain populations within a state, and therefore may not accurately depict the full picture of influenza activity for the whole state.

*Data displayed in this map are based on data collected in ILINet, whereas the State and Territorial flu activity map are based on reports from state and territorial epidemiologists. The data presented in this map is preliminary and may change as more data is received.

*Differences in the data presented by CDC and state health departments likely represent differing levels of data completeness with data presented by the state likely being the more complete.

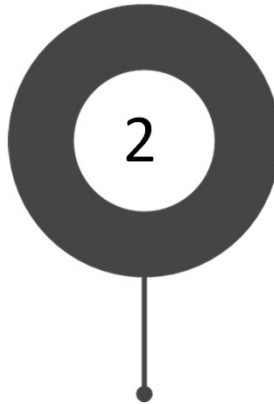
*For the data downloaded you can use Activity Level for the number and Activity Level Label for the text description.

*This graphic notice means that you are leaving an HHS Web site.

For more information, please see CDC's Exit Notification and Disclaimer policy.

For more information on the methodology, please visit Outpatient Illness Surveillance methods section.

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Practice prevention.

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Prevention



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Current Guidance on PPE

- When performing aerosol-generating procedures on patients who are not suspected or confirmed to have SARS-CoV-2 infection, ensure that DHCP correctly wear the recommended PPE (including consideration of a NIOSH Approved particulate respirator with N95 filters or higher as SARS-CoV-2 community transmission increases) and use mitigation methods such as four-handed dentistry, high evacuation suction, and dental dams to minimize droplet spatter and aerosols.
 - Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

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The Reality:

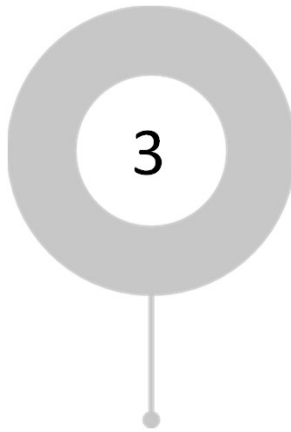


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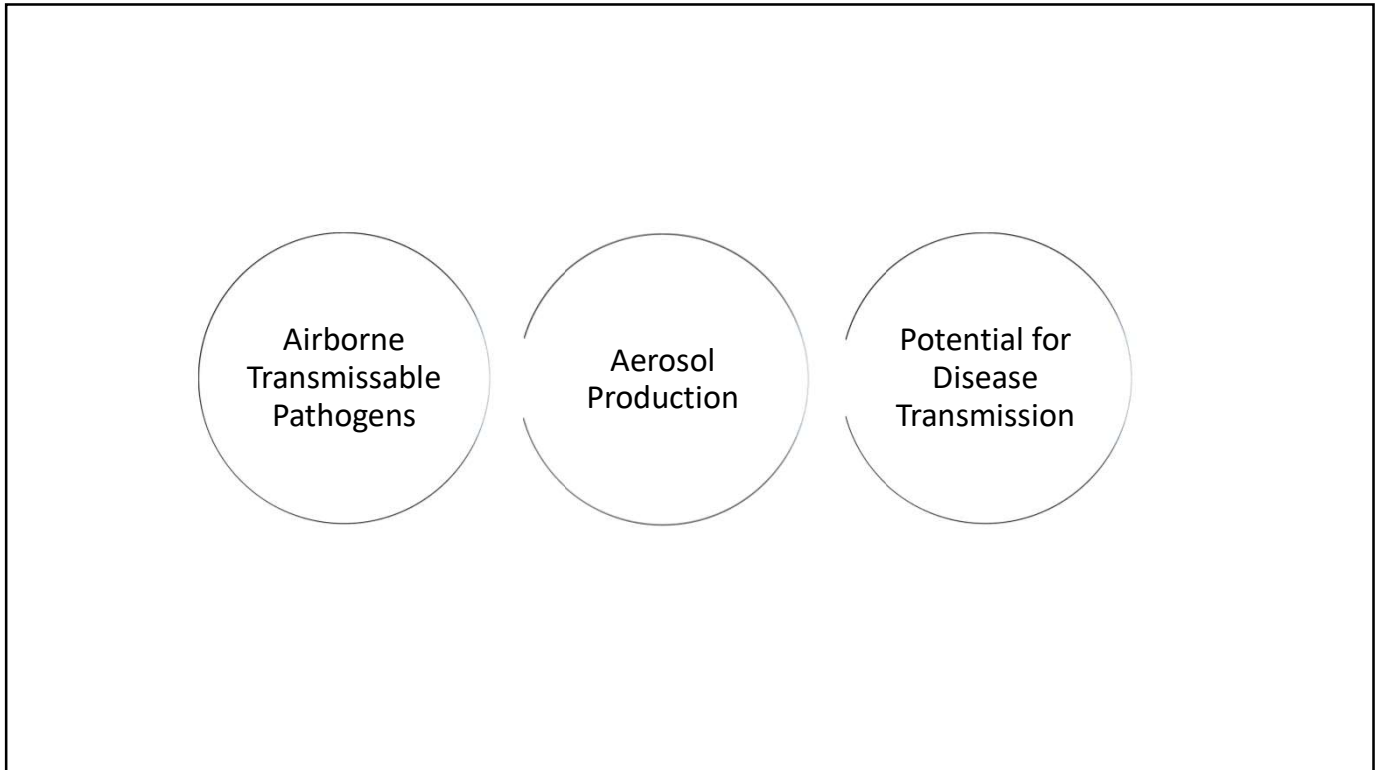
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Maximize ventilation.

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CDC Guidance on Ventilation



DEFINITION

Ventilation

Ventilation is a term with different meanings to different people. For the purpose of this webpage, "ventilation" includes:

- Indoor air movement and dilution of viral particles through mechanical or nonmechanical (also called natural) means.
- Filtration through central heating, ventilation and air conditioning (HVAC) systems and/or in-room air cleaners (portable or permanently mounted).*
- Air treatment with Ultraviolet Germicidal Irradiation (UVGI) systems (also called Germicidal Ultraviolet or GUV).*

* These air cleaning techniques are sometimes referred to as "equivalent ventilation." They are not a substitute for meeting minimum outdoor air delivery requirements that may be specified in national, state, and local building codes.

<https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>

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CDC Guidance on Ventilation

How Much Ventilation Is Enough?

Aim for 5 Air Changes per Hour (ACH)

When possible, aim for 5 or more air changes per hour (ACH) of clean air to help reduce the number of germs in the air.

This can be achieved through any combination of central ventilation system, natural ventilation, or additional devices that provide equivalent ACH (eACH*) to your existing ventilation. Supplying or exhausting an amount of air (use the larger of the two values but do not add them together) that is equal to all the air in a space is called an air change. Multiplying that amount by 5 and delivering it over one hour results in 5 ACH.

<https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>

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CDC Guidance on Ventilation

Use portable or built-in high-efficiency particulate air (HEPA) fan/filtration systems (also called air cleaners or air purifiers).

- Use HEPA systems to enhance air cleaning (especially in higher risk areas such as a medical office or areas frequently inhabited by people with a higher likelihood of having COVID-19 and/or an increased risk of getting COVID-19). See FAQ #5 below on HEPA filters and in-room HEPA air cleaners.
- In-room air cleaners that use filters less efficient than HEPA filters also exist and can contribute to room air cleaning. However, they should be clearly labeled as non-HEPA units.
- Some air cleaners/air purifiers use technologies other than filtration. See FAQ #8 for a detailed discussion of factors to consider before using these other technologies.

<https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>

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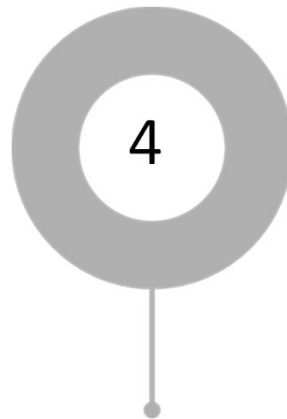
CDC Guidance on Ventilation

For dental facilities with open floor plans, strategies to prevent the spread of pathogens include:

- At least 6 feet of space between patient chairs.
- Adjunct use of portable HEPA air filtration systems to enhance air cleaning
- Physical barriers between patient chairs. Easy-to-clean floor-to-ceiling barriers will enhance effectiveness of portable HEPA air filtration systems (check to make sure that extending barriers to the ceiling will not interfere with fire sprinkler systems).
- Operatories oriented parallel to the direction of airflow when possible.
- Where feasible, consider patient orientation carefully, placing the patient's head near the return air vents, away from pedestrian corridors, and toward the rear wall when using vestibule-type office layouts.

<https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>

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Screen patients.

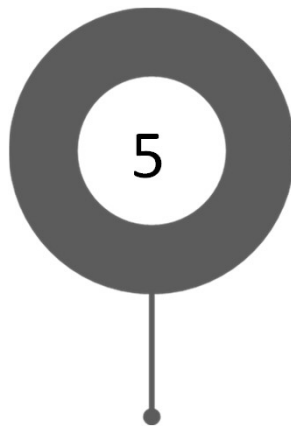
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Screening Patients

- Ask about respiratory symptoms at confirmation
- Postpone tx if fever or respiratory symptoms
- Take temps in the treatment room
 - Make it part of every appointment along with checking blood pressure



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Don't come to work sick.

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CDC Guidance on HCP with COVID-19 Exposure

Higher-risk exposure

In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

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CDC Guidance on HCP with COVID-19

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 and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g., rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified.

HCP with mild to moderate illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 7 days have passed *since symptoms first appeared* if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **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.

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

HCP who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

*Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

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HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:

- At least 10 days and up to 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.
- The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered when determining the appropriate duration for specific HCP. For a summary of the literature, refer to [Ending Isolation and Precautions for People with COVID-19: Interim Guidance \(cdc.gov\)](#)

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.

- Use of a test-based strategy (as described below) 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.

Test-based strategy

HCP who are symptomatic could return to work after the following criteria are met:

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

HCP who are not symptomatic could return to work after the following criteria are met:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

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What to do if you have respiratory symptoms?

- **Stay home while symptomatic**
- **Test when respiratory symptoms are present**
 - Home COVID test
 - PCR test for COVID, Flu, and RSV
- **If COVID+ follow CDC guidance on return to work**



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Stay Well!

Thank you for participating.

Thank you again to our sponsor.



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