

MEMORANDUM

To: Prehospital Response Personnel

From: Daniel Shepherd, MD 
Ventura County EMS Agency medical Director

Re: Updated Sars CoV-2 Prehospital Guidelines (Version 8)

Date: October 06, 2021

The recent increase in COVID-19 cases and hospitalizations due to the Delta Variant has prompted Ventura County Public Health to urge unvaccinated individuals to get a COVID-19 vaccine and advise the community to continue strict implementation of Infection Prevention and Control (IPC) practices. General infection control measurements such as hand hygiene, equipment disinfection, social distancing, and the utilization of appropriate PPE continue to be considered best practices in terms of maintaining one's safety and reducing disease transmission within the community.

The current sequencing efforts confirm that the Delta variant has become the dominant strain of the COVID-19 virus in the County. The CDC has provided a comprehensive summary on what we know regarding the Delta variant:

- 1) The Delta variant is highly contagious (more than 2x previous variants).
- 2) Current data suggests that the Delta variant may cause more severe illness than previous variants in unvaccinated people.
- 3) Unvaccinated people are much more likely to get infected, and therefore transmit the virus.
- 4) Fully vaccinated people with the Delta variant may still spread the virus, however they appear to do so for a shorter period of time.

Emergency Medical Service (EMS) recommendations are based on the most up-to-date clinical recommendations and information from public health authorities. EMS plays a vital role in responding to medical emergencies, triaging patients, and providing emergency medical treatment and transportation for ill or injured persons. Below are some key points to remember regarding SARS CoV-2:

- The primary mode of transmission of SARS-CoV-2 is via exposure to respiratory fluids carrying the infectious virus. There are three principal modes by which this can occur:
 - Inhalation of very fine respiratory droplets and aerosolized particles
 - Deposition of respiratory droplets and particles on exposed mucous membranes (splashed and/or sprays to mouth, nose, or eyes)
 - Touching mucous membranes with contaminated hands

- EMS personnel have a higher chance of encountering SARS-CoV-2 patients due to responding to multiple calls per day over a variety of geographic areas and entering different types of facilities (businesses, correctional facilities, long-term care facilities, residential homes, etc.).
- An infected person can spread COVID-19 two days prior to having any symptoms (or, if they are asymptomatic, two days before the positive specimen was collected).
- Implementing the universal use of personal protective equipment, guided by the county's SARS-CoV-2 transmission, is imperative in order to protect prehospital healthcare providers and decrease transmission.
- While the use of universal precautions is not new to EMS personnel, COVID-19 requires greater protection, especially when performing aerosol-generating procedures (AGPs).
- When responding to patients suspected of having a SARS-CoV-2 infection, close coordination and effective communication are important among the 911 Public Safety Answering Points/Emergency Communication Centers (PSAP/ECCs).
- Symptoms for SARS CoV-2 vary in complexity and severity and can range anywhere from severe respiratory illness to a mild sore throat. It's not uncommon for patients with SARS CoV-2 to be completely asymptomatic.
- All patients (if tolerated), regardless of COVID-19 symptoms, should be instructed to practice source control. Contact should be minimized as much as possible until a cloth face covering, or facemask is on the patient.
- The most effective ways to prevent infection and/or transmission are by:
 - Practicing frequent hand hygiene, especially after every patient contact
 - Wearing all recommended PPE
 - Vaccination
 - Encouraging all patients to use a mask
 - Cleaning and disinfecting surfaces
 - Avoiding touching your face while working
 - Change your clothes before getting into your personal vehicle after your shift
 - Wash uniforms after every shift. Change your uniform during a shift if you suspect that it has become soiled following a patient contact.

VENTURA COUNTY EMS AGENCY COVID-19 PREHOSPITAL GUIDELINES

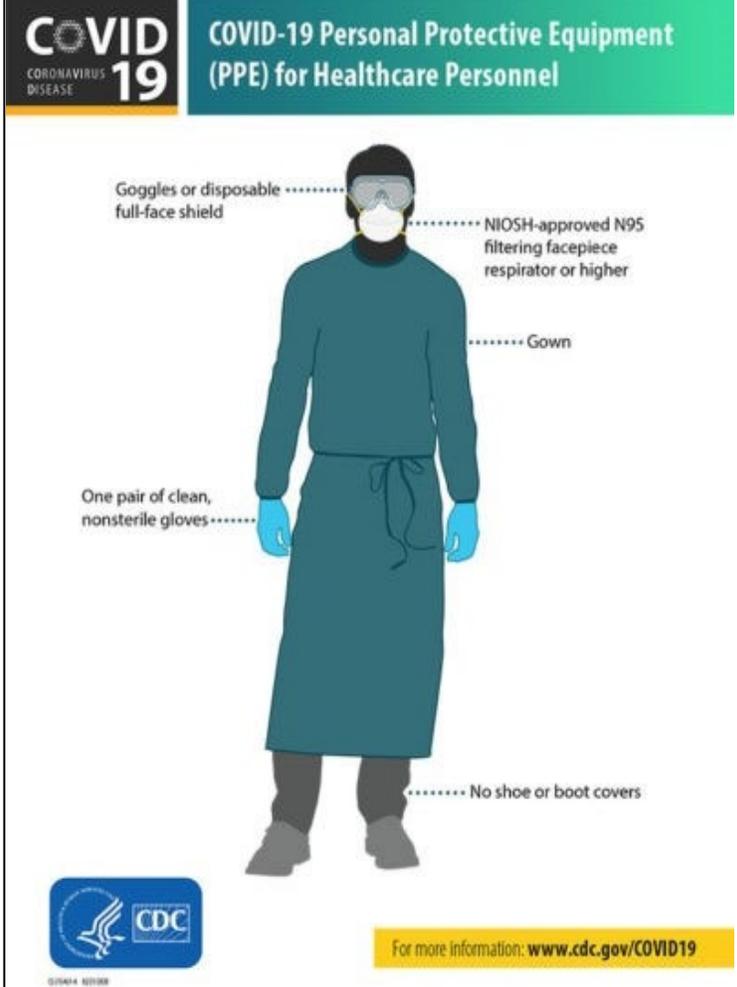
If SARS-CoV-2 infection is not suspected:

1. N95 is preferred per CDC, but a well-fitting surgical mask may be used
 - o A NIOSH-approved N95 or equivalent or higher-level respirator for all aerosol-generating procedures (AGPs)
 - o A NIOSH-approved N95 or equivalent or higher-level respirator for **unvaccinated personnel**
2. Gloves
3. Eye Protection
4. **PATIENT SHOULD ALSO HAVE A PROCEDURE MASK APPLIED IMMEDIATELY**

If SARS-CoV-2 infection is suspected:

IMPLEMENT FULL PPE FOR PATIENT CONTACTS WHERE PRE-NOTIFICATION FROM DISPATCH OCCURS, AND/OR WHERE THERE IS CONCERN FOR COVID-19 (SIGNS AND SYMPTOMS OF ACUTE RESPIRATORY ILLNESS SUCH AS FEVER, COUGH, SHORTNESS OF BREATH, DIFFICULTY BREATHING AND/OR GASTROINTESTINAL SYMPTOMS SUCH AS ABDOMINAL PAIN, NAUSEA/VOMITING AND/OR DIARRHEA) OR RECENT HISTORY (<2 weeks) OF SARS-CoV-2 exposure:

1. Gloves
2. GOWN OR NFPA 1999-2013 APPROVED BLOODBORNE PATHOGEN PROTECTIVE CLOTHING
3. GOGGLES OR DISPOSABLE FULL-FACE SHIELD
 - a. Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
 - b. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
4. N95 OR HIGHER* (IF AVAILABLE) RESPIRATOR
*N100, P100, OR AIR PURIFYING RESPIRATOR (APR)
5. **ALL PATIENTS SHOULD HAVE A SURGICAL MASK APPLIED IMMEDIATELY**



General Guidelines / Best Practices

- **Full PPE:** EMS personnel should continue to adhere to [Standard](#) and [Transmission-Based Precautions](#), including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses.
- Assume that possible COVID-19 patients may have called for EMS assistance with a non-respiratory complaint. Be prepared and screen every patient for signs and symptoms until you are able to rule out respiratory illness.
- Begin assessment from a distance of at least six feet and ensure the patient dons a procedure mask as soon as possible.
- Limit the number of providers that make patient contact based on the patient's condition and level of care needed.
- Do not rely on dispatch pre-arrival instructions and PPE recommendations to catch all possible COVID-19 cases. Maintain a high degree of suspicion and repeat screening *on every call, for every patient*. Protect yourself and your prehospital teammates.
- Have all necessary PPE ready and available on every single call.
- Ask the patient if they have tested positive for COVID-19 or if they have been exposed to someone that has tested positive. If the answer to either of these questions is yes, treat the patient as positive for COVID-19.
- **If you are EVER in doubt about a patient's status, don full PPE. Limit your exposure and protect yourselves and your fellow first responders/prehospital personnel!**

Treatment and Transport Guidelines

- Limit treatment activities unless the patient has an unstable condition that requires intervention.

VENTURA COUNTY EMS AGENCY COVID-19 PREHOSPITAL GUIDELINES

- Ensure every patient is wearing a procedure mask.
- Ensure all personnel are wearing appropriate PPE.
 - If the ambulance does not have an isolated driver's compartment, the driver should remove the goggles, gloves, and gown or NFPA rated clothing and perform hand hygiene. An N95 respirator should continue to be used during transport.
- If a nasal cannula is used, a facemask should be worn over the cannula.
- Nebulized albuterol has no documented clinical benefit over the administration of albuterol via metered dose inhaler with a spacer. If available, use the patient's MDI with a spacer and defer nebulizer treatment.
 - Dose of MDI is 4 puffs x 1, then 2 puffs q 15 min prn shortness of breath and/or wheezing.
 - If a nebulizer treatment must be given, attempt to perform in an open setting (e.g. outside of ambulance).
- CPAP and nebulizer treatments should be discontinued prior to entering the Emergency Department.
 - Place the patient in a nonrebreather mask and titrate supplemental oxygen to a goal oxygen saturation of > 94%. If possible, use a lower flow setting (12 LPM) to reduce potential for aerosolization.
- Advise the base hospital whenever oxygen therapy is being administered, regardless of device/flow setting. If you don't feel CPAP or nebulizer therapy can be discontinued, advise ahead of time so that the receiving facility can take appropriate actions prior to ambulance arrival.
- Remember – Full PPE is essential for any prehospital personnel caring for patients that require any respiratory intervention(s).
 - An N95 or higher-level respirator, gown or NFPA 1999-2013 rated protective clothing, and goggles or disposable full-face shield shall be worn when any aerosolizing procedure is performed.
 - BVMs, and other ventilatory equipment, should be equipped with HEPA filtration to filter expired air – if available.
 - EMS systems should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive-pressure ventilation.
 - If possible, the rear doors of the stationary transport vehicle should be opened and the HVAC system should be activated during AGPs. This should be done away from pedestrian traffic.
 - If possible, discontinue AGPs prior to entering the destination facility or communicate prior to arrival.
- Family members should only be taken as a rider in the event that the patient is an unaccompanied minor or has some other special circumstance that limits the personnel's ability to assess the patient.
- Ensure the ambulance's ventilation system is in non-recirculating mode in order to maximize the volume of fresh air brought into the vehicle from the outside. Utilize the exhaust fan in the ambulance patient compartment to draw air out of the vehicle.
- If transported, ensure that the exhaust vent is on in the patient compartment to draw air out.
- Establish base hospital contact as soon as possible and advise of "possible COVID-19 patient." Include signs and symptoms, history of present illness, and any other relevant information.
- For cases of unprotected exposure to a high-risk or confirmed COVID-19 patient, notify agency supervisor.

Decontamination of Gear and Equipment

- Decontamination of gear and equipment should be performed in PPE.
- Dispose of disposable respirator, respirator filters (if applicable), gown, and gloves in accordance with your agency's policy/protocol. Conservation of scarce resources should be practiced in accordance with your agency's established policy/protocol.
 - The [VCPH Donning and Doffing Personal Protective Equipment video](#) can be utilized for training purposes.
- Non-disposable items should be cleaned with an approved cleaning solution, in accordance with manufacturer's recommendation and established agency guidelines
 - Cleaning should happen prior to disinfection; some chemicals are both cleaners and disinfectants
 - Ensure that the chemical used is listed on the EPA [List N](#) as a hospital-grade disinfectant. Refer to the product's label for the appropriate *contact time*
 - **Contact time:** Time a disinfectant is in direct contact with the surface or item to be disinfected. For surface disinfection, the surface must remain visibly wet for the entire contact time.
 - In most cases, fogging, fumigation, and wide-area or electrostatic spraying are not recommended as primary methods of surface disinfection and have several safety risks to consider, unless specified as a method of application on the product label.

VENTURA COUNTY EMS AGENCY COVID-19 PREHOSPITAL GUIDELINES

- NFPA 1999-2013 protective clothing that is visibly contaminated with bodily fluid should be washed following the agency's prescribed laundry procedures.
- Ambulances used to transport symptomatic patients should be cleaned utilizing approved commercially available cleaning products or diluted bleach solution (1/4 cup bleach in 1 gallon of water). Refer to agency guidelines in regard to authorized cleaning procedures.

Ambulance Considerations

Considerations for vehicle configuration when transporting a patient with suspected or confirmed SARS-CoV-2 infection

- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
- When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
 - Before entering the isolated driver's compartment, the driver (if they were involved in direct patient care) should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
 - Close the door/window between these compartments before bringing the patient on board.
 - During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
 - If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.
 - After patient unloading, allowing a few minutes with ambulance module doors open will rapidly dilute airborne viral particles.
- If a vehicle without an isolated driver compartment must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting to create a pressure gradient toward the patient area.
 - Before entering the driver's compartment, the driver (if they were involved in direct patient care) should remove their gown, gloves and eye protection and perform hand hygiene to avoid soiling the compartment. They should continue to wear their NIOSH-approved N95 or equivalent or higher-level respirator.

Miscellaneous Items / Points to Remember

- Hand Hygiene remains the number one way to protect yourself and others
 - EMS personnel should perform hand hygiene by using alcohol-based hand sanitizer (ABHS) with 60-95% alcohol.
 - Hand sanitizing should also be methodical and mindful, ensuring the entire surface of the hand is covered with ABHS.
 - After hand sanitizing, the surface of the hand should remain wet for 20 seconds.
 - If hands are visibly soiled, EMS personnel must wash hands with soap and water.
 - Hand hygiene should be done prior to donning gloves, in between patients, after contact with environmental surfaces, prior to donning PPE, after doffing PPE, and after touching one's face.
- **Aerosol Generating Procedures (AGPs):** Some procedures performed on COVID-19 patients could generate infectious aerosols. In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously and avoided if possible. EMS clinicians should exercise caution if an aerosol-generating procedure [e.g., bag valve mask (BVM) ventilation, oropharyngeal suctioning, endotracheal intubation, nebulizer treatment, continuous positive airway pressure (CPAP)], or resuscitation involving emergency intubation or cardiopulmonary resuscitation (CPR) is necessary. If possible, consult with medical control for specific guidance before performing aerosol-generating procedures.
- Continue to use the CDC exposure risk assessment and guidelines issued by CDC ([link below](#)) for further information on COVID-19 exposure categories.
- Ensure crew rosters are accurate in CAD. In the event there is an exposure, this information may be helpful in the crew identification and notification process.
- To reduce contamination and possible exposure, minimize loose and uncovered equipment in the patient compartment area.

The currently licensed and authorized vaccines in the United States are highly effective at protecting vaccinated people from severe disease and death from COVID-19. Fully vaccinated people are less likely to become infected, and if infected, less likely to develop symptoms of COVID-19. This guidance document was adopted from the latest CDPH guidance on quarantine for Health Care Personnel (HCP) Exposed to SARS-CoV-2. VCPH continues to recommend a quarantine period of 14 days for unvaccinated or partially vaccinated individuals after SARS-CoV-2 exposure, based on estimates of the upper bounds of the COVID-19 incubation period. However, a 14-day quarantine for unvaccinated health care personnel may not be feasible during critical staffing shortages when there are not enough staff to provide safe patient care.

Quarantine for Exposed Prehospital Personnel

EMS provider should continue to use the CDC's risk assessment framework to determine exposure risk for Prehospital Personnel who have potential exposure to patients, visitors, and other personnel with confirmed COVID-19 while working in the field. CDC guidance for assessing travel and community-related exposures should continue to be applied to personnel who have potential exposures outside of work (e.g. household), and among staff exposed to each other while working in non-patient care areas (e.g. administrative offices). The exposure period begins two days before the onset of symptoms or, if asymptomatic, two days before test specimen collection for the individual with confirmed COVID-19.

- Unvaccinated or partially vaccinated personnel
 - Asymptomatic unvaccinated personnel may discontinue quarantine after **Day 10** from the date of last exposure **with or without testing**.
 - Personnel infected within the last 3 months who have high risk workplace or community exposures do not need to be restricted from work as long as they are asymptomatic and continue to follow all recommended infection prevention and control practices, including universal source control, and continue monitoring as outlined in this guidance.

At this time, VCPH does not recommend using the CDC guidance for staffing shortage mitigation strategies because shortening the duration of a work restriction might result in additional transmission.

- Fully vaccinated personnel (i.e., greater or equal to two weeks following receipt of the second dose in a 2-dose series, or greater or equal to two weeks following receipt of one dose of a single-dose vaccine).
 - Fully vaccinated personnel with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure as long as they were fully vaccinated \pm before the exposure AND they have not developed any symptoms since their exposure.
 - Exposed personnel should **self-monitor** for COVID-19 symptoms and **strictly adhere to all** recommended non-pharmaceutical interventions (e.g., wearing a mask, whenever possible maintaining a distance of at least 6 feet from non-household members, frequently performing hand hygiene, avoiding crowds and poorly ventilated indoor spaces) for 14 days following the last date of exposure.
 - Work restrictions for fully vaccinated personnel with higher-risk exposures should still be considered for HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact level of protection provided by the COVID-19 vaccine.
 - Fully vaccinated people should get tested 3-5 days after their exposure, even if they don't have symptoms.

Return to Work Criteria for Prehospital Personnel with SARS-CoV-2 Infection

- *Personnel with mild to moderate illness who are not severely immunocompromised* can return to work:
 - At least 10 days after symptom onset **AND**
 - At least 24 hours since last fever without fever-reducing medication **AND**
 - Symptoms (e.g., cough, shortness of breath) have improved
- *Asymptomatic Personnel* who are not severely immunocompromised should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms. If they develop symptoms, follow the above guidance.

- *Symptomatic HCP with severe or critical illness or who are severely immunocompromised* can return to work:
 - At least 10 days and up to 20 days have passed since symptoms first appeared **AND**
 - At least 24 hours since last fever without fever-reducing medication **AND**
 - Symptoms (e.g., cough, shortness of breath) have improved
 - Consider consultation with infection control experts
- In most cases, testing of laboratory-confirmed cases is not recommended for return to work due to the prolonged detection of SARS-CoV-2 RNA without direct correlation to viral culture. Prehospital personnel who are **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. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy, in consultation with occupational health, could be considered for determining when these HCP may return to work.

Definition of High-Risk Occupational and Community Exposure

- *High-risk occupational exposure*

In the healthcare setting, the following exposures to a confirmed infectious COVID-19 case* are considered high-risk:

 - HCP who performed or were present in the room during a high-risk respiratory aerosol-generating procedure (AGP) where the confirmed case patient was not masked (e.g. intubation or extubation, bronchoscopy, open suctioning) and where the HCP was missing some element of PPE (either eye protection or a respirator). This includes HCP that wore all other recommended PPE but who wore a facemask instead of a respirator during an AGP.
 - HCP who had close contact (i.e. they were within 6 feet for a cumulative total of 15 minutes or more in a 24-hour period and/or they had direct unprotected contact with infectious secretions/excretions) with a confirmed case:
 - While not wearing a respirator or facemask
 - While not wearing eye protection if the case was not wearing a facemask or cloth face covering.
- *Community Exposure*

In the community, a close contact is any of the following:

 - Persons who were within 6 feet of the case for a total of 15 minutes or more over a 24-hour period OR
 - Persons who had unprotected contact with the case's body fluids and/or secretions, for example, being coughed or sneezed on or sharing drinks or food.

**COVID-19 cases are considered to be infectious beginning 2 days prior to symptom onset (or initial positive viral test if case is asymptomatic) until the time they meet criteria for discontinuing isolation.*

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

Exposure	Personal Protective Equipment Used	Work Restrictions for <u>Unvaccinated</u> HCP
Higher-risk: HCP who had prolonged ¹ close contact ² with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection	<ul style="list-style-type: none"> • HCP not wearing a respirator or facemask⁴ OR • HCP not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask OR • HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure¹ 	<ul style="list-style-type: none"> • Exclude from work for 14 days after last exposure. • Perform SARS-CoV-2 testing immediately (but not earlier than 2 days after the exposure) and, if negative, again 5-7 days after the exposure. Criteria for use of post-exposure prophylaxis are described can be found here. • Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19. • Any HCP who develop fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
Lower-risk: HCP other than those with exposure risk described above	<ul style="list-style-type: none"> • N/A 	<ul style="list-style-type: none"> • No work restrictions or testing. • Follow all recommended infection prevention and control practices, including monitoring themselves for fever or symptoms consistent with COVID-19 and not reporting to work when ill. Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
<p>HCP with travel or community exposures should consult their occupational health program for guidance on need for work restrictions. HCP who have traveled should continue to follow CDC travel recommendations and requirements, including restriction from work, when recommended for any traveler. HCP with community exposures should be restricted from work if they have a community exposure for which quarantine is recommended.</p>		

Footnotes:

1. Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, it is reasonable to consider an exposure of 15 minutes or more as prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, **any duration** should be considered prolonged if the exposure occurred during performance of an [aerosol generating procedure](#).
2. Data are limited for the definition of close contact. For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.
3. Determining the time period when the patient, visitor, or HCP with confirmed SARS-CoV-2 infection could have been infectious:

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

4. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets [criteria for discontinuation of Transmission-Based Precautions](#)
5. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.
6. In general, individuals with SARS-CoV-2 infection should be considered potentially infectious beginning 2 days after their exposure until they meet [criteria for discontinuing Transmission-Based Precautions](#).
7. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
8. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with SARS-CoV-2 infection, facemasks still confer some level of protection to HCP, which was factored into this risk assessment. Cloth masks are not considered PPE because their capability to protect HCP is unknown.

Definitions:

Fully vaccinated: Greater or equal to two weeks following receipt of the second dose in a 2-dose series, or greater or equal to two weeks following receipt of one dose of a single-dose vaccine)

Unvaccinated refers to a person who does not fit the definition of “fully vaccinated,” including people whose vaccination **status is not known**, for the purposes of this guidance.

Immunocompromised: For the purposes of this guidance, moderate to severely immunocompromising conditions include, but might not be limited to:

- Active treatment for solid tumor and hematologic malignancies
- Receipt of solid-organ transplant and taking immunosuppressive therapy
- Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection (people with HIV and CD4 cell counts <200/mm³, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV)
- Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory. Other factors, such as end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about need for work restriction if the healthcare provider had close contact with someone with SARS-CoV-2 infection. However, fully vaccinated people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility, even when not otherwise recommended for fully vaccinated individuals.
- Ultimately, the degree of immunocompromise for the healthcare provider is determined by the treating provider, and preventive actions are tailored to each individual and situation.

To read the full guidance document go to [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#)