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Respiratory equality: let's stop playing favorites with COVID-19 in the healthcare setting

Catherine L. Passaretti MD^{1,2} , Werner Bischoff MD, PhD² , Justin Chan MD, MPH^{3,4}, Daniel J. Diekema MD⁵, Shira Doron MD⁶, Carolee Estelle MD⁷, Jesse T. Jacob MD⁸, Tsun Sheng N. Ku MD⁹, Surbhi Leekha MBBS, MPH¹⁰, Richard A. Martinello MD¹¹ , Vidya K. Mony DO¹², L. Silvia Munoz-Price MD, PhD¹³, Rekha Murthy MD¹⁴, Judith A. O'Donnell MD¹⁵, David H. Priest MD, MPH¹⁶ , Mindy M. Sampson DO¹⁷, Thomas J. Sandora MD, MPH^{18,19} , Graham M. Snyder MD²⁰ , Michael P. Stevens MD, MPH²¹ , Julie E. Szymczak PhD²² , Francesca Torriani MD²³, Deborah S. Yokoe MD, MPH²⁴ and Jonas Marschall MD, MSc, DTM&H²⁵

¹Department of Infection Prevention, Advocate Health, Charlotte, NC, USA, ²Division of Infectious Diseases, Department of Internal Medicine, Wake Forest University School of Medicine, Winston-Salem, NC, USA, ³NYC Health + Hospitals/Bellevue, New York, NY, USA, ⁴NYU Grossman School of Medicine, New York, NY, USA, ⁵Department of Medicine, Maine Health-Maine Medical Center, Portland, ME, USA, ⁶Department of Medicine, Division of Geographic Medicine and Infectious Diseases, Tufts Medical Center, Boston, MA, USA, ⁷Division of Infectious Diseases and Geographic Medicine, Department of Internal Medicine, University of Texas Southwestern Medical Center, Dallas, TX, USA, ⁸Department of Medicine, Division of Infectious Diseases, Emory University School of Medicine, Atlanta, GA, USA, ⁹Billings Clinic, Billings, MT, USA, ¹⁰University of Maryland School of Medicine, Baltimore, MD, USA, ¹¹Departments of Internal Medicine and Pediatrics, Infectious Diseases, Yale School of Medicine, New Haven, CT, USA, ¹²Santa Clara Valley Healthcare, San Jose, CA, USA, ¹³Emerald Coast Infectious Diseases, Destin, FL, USA, ¹⁴Cedars-Sinai and UCLA David Geffen School of Medicine, Los Angeles, CA, USA, ¹⁵Division of Infectious Diseases, Department of Medicine, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA, USA, ¹⁶Novant Health, Winston-Salem, NC, USA, ¹⁷Division of Infectious Diseases & Geographic Medicine, Department of Medicine, Stanford University, Stanford, CA, USA, ¹⁸Division of Infectious Diseases, Boston's Children's Hospital, Boston, MA, USA, ¹⁹Department of Pediatrics, Harvard Medical School, Boston, MA, USA, ²⁰Division of Infectious Diseases, Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, PA, USA, ²¹West Virginia University School of Medicine, Morgantown, WV, USA, ²²Division of Epidemiology, Department of Internal Medicine, University of Utah Spencer Fox Eccles School of Medicine, Salt Lake City, UT, USA, ²³Division of Infectious Diseases and Global Health, University of California San Diego, San Diego, CA, USA, ²⁴University of California San Francisco Health, San Francisco, CA, USA and ²⁵University of Arizona College of Medicine - Phoenix, Phoenix, AZ, USA

Early in the COVID-19 pandemic, the Centers for Disease Control and Prevention (CDC) developed protocols for healthcare personnel (HCP) return-to-work (RTW) after SARS-CoV-2 infection prioritizing patient and HCP safety amidst the uncertainty of a novel virus. As we enter our fifth winter with SARS-CoV-2, the virus is now endemic, and there is a need for healthcare systems to reevaluate and adjust policies to reflect the current environment. While the timeline for updated healthcare COVID-19 guidance from the CDC and the Healthcare Infection Control Practices Advisory Council (HICPAC) remains uncertain, healthcare systems need practical strategies to manage COVID-19 alongside other respiratory virus infections (RVIs) before the 2024–2025 season.

Fortunately, the epidemiology of SARS-CoV-2 has evolved, and its severity has lessened¹ due to the availability of vaccines, proven therapeutics, and population-level immunity from prior infections. Despite this, CDC HCP RTW guidance, last updated in late 2021, continues to treat COVID-19 differently from other endemic RVIs with significant clinical impact such as influenza and RSV. This exceptionalism causes HCP confusion and poses barriers to practical healthcare delivery, without enhancing patient safety. This also presents a lost opportunity to apply lessons learned

during the COVID-19 pandemic regarding respiratory virus transmission in a more standard manner across RVI prevention. This letter provides insights into how leaders in healthcare epidemiology, including members of the Society of Healthcare Epidemiology of America (SHEA) Board of Trustees, are navigating COVID-19 RTW in this evolving landscape.

Current state

The existing CDC guidance for HCP COVID-19 RTW recommends a 10-day isolation period if testing is not performed, or RTW 7 days after symptom onset if afebrile for 24 hours without antipyretics, symptomatically improved and with negative test results within 48 hours of RTW.² CDC HCP COVID-19 RTW guidelines are far more stringent than the longstanding guidance for other RVIs that recommends HCP RTW once fever-free for 24 hours (without antipyretics) and symptoms improved.³ The current HCP RTW guidance also contrasts with CDC's updated community guidance from March 2024, which adopted a unified approach for all RVIs, including COVID-19, emphasizing staying home while ill followed by 5 days of additional protective measures such as masking.⁴ A June 2023 survey found that only 16% of hospitals were following the CDC's HCP RTW recommendations, highlighting a disconnect between guidance and practice.⁵ This may reflect operational challenges and/or risk assessments by facilities that CDC guidance exceeds what is necessary to maintain a safe environment.

Corresponding author: Catherine L. Passaretti; Email: cpassare@wakehealth.edu

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Healthcare personnel masking protocols, mandated by some state health departments or adopted by individual systems during respiratory viral season or to control RVI outbreaks, have been used, albeit inconsistently, even before the pandemic. Although the CDC includes mask use for source control as part of standard precautions and respiratory hygiene,⁶ its application, especially regarding RTW, has been uneven.

Challenges with continuing current guidance

Discrepancies in COVID-19 management compared to other RVIs, and inconsistencies between healthcare and community practices, create confusion among HCP and pose operational challenges. At a time when the healthcare workforce is already stressed, adhering to the longer HCP isolation duration recommended by the current CDC guidance can exacerbate workforce shortages, disrupting service lines and patient care.

Practical barriers such as the cost and access to testing required to confirm a COVID-19 diagnosis and reduce RTW timeframes, are common. Moreover, many healthcare leave policies have reverted to pre-pandemic norms, forcing HCP to use their limited paid time off to stay home when they contract COVID-19. This may lead to underreporting of illness and inequities, as those with more paid time off are more likely to stay home when sick. HCP who might benefit from prompt antiviral treatment may opt not to test to avoid missing work. Collectively, the authors have observed that this has contributed to reduced testing by sick HCP and increased presenteeism, undermining overall safety efforts.

Beyond these operational issues, the current CDC HCP COVID-19 RTW guidance also mistakenly places an exclusive focus on SARS-CoV-2, overlooking the significance and impact of transmission of other RVIs, such as influenza and RSV from HCP to patients.

Infection prevention leaders' current thinking

The current CDC HCP RTW guidance is well-intentioned but outdated and misaligned with community practices and messaging for other endemic RVIs. SHEA leaders advocate for a unified HCP RTW approach across all RVIs, including COVID-19, allowing HCP to return to work when fever-free for at least 24 hours without fever-reducing medications and symptomatically improved. HCP should wear a medical-grade mask while in the workplace for at least 5 additional days.^{7,8} Testing should be reserved for symptomatic HCP in consultation with a healthcare provider.

The Centers for Disease Control and Prevention and public health departments can take this opportunity to adopt lessons learned from COVID-19 and guide healthcare facilities to emphasize source control masking as a key element of standard precautions and respiratory hygiene, promoting a more consistent and protective environment.⁹

Conclusion

As the healthcare landscape has evolved post-pandemic, preventative strategies must also adapt. SHEA leaders recommend a

pragmatic, harmonized approach to HCP RTW protocols across all RVIs to reduce confusion, streamline care, promote equity, and enhance safety for both patients and HCP. This approach also has the potential to reduce overall presenteeism and transmission of all RVIs from HCPs to patients.¹⁰ By evolving our practices to meet current realities, healthcare systems can maintain high standards of care and operational efficiency. CDC-supported research could further validate this approach and guide future refinements.

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