HUNT COUNTY HEALTH DEPARTMENT
2700 JOHNSON STREET
GREENVILLE, TEXAS 75401
903-408-4140 FAX 903-454-3721

HUNT COUNTY HEALTH AUTHORITY
ORDER REGARDING RETURNING TO WORK FOR
COVID-19 PATIENTS AND CLOSE CONTACTS

WHEREAS, the Hunt County Health Authority (the "Health Authority") is the local governing health authority for Hunt County, Texas pursuant to the Texas Health and Safety Code and by order of the Commissioners Court of Hunt County, Texas; and

WHEREAS, pursuant to authority granted in Texas Health and Safety Code Sections 81.082 and 121.024 together with authority granted in Texas Administrative Code Sections 85.1 and 97.6, unless specifically restricted by the Texas Department of State Health Services a local Health Authority has supervisory authority and control over the administration of communicable disease control measures within its jurisdiction when necessary to protect the public health; and

WHEREAS, in accordance with that authority and in furtherance of the administration of communicable disease control measures and protection of the public health I am issuing this order to address required isolation timelines for people who have tested positive for COVID-19 or been exposed to others who have tested positive for COVID-19; now therefore

IT IS HEREBY ORDERED THAT:

1. Hunt County will follow the guidelines issued by the CDC on July 22, 2020 (the "Duration of Isolation and Precautions for Adults with COVID-19") attached hereto as Exhibit "A" and on July 17, 2020 ("Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)") attached hereto as Exhibit "B," except that:

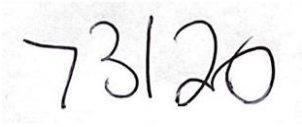
   For all non-Health Care Professionals and for Health Care Professionals, other than those who work at Hunt Regional Medical Center, the time-based end of isolation (also called "symptom-based strategy") will be 13 days after the date that symptoms first appeared, and/or 13 days after the date of their first positive viral diagnostic test (rather than 10 days for each such circumstance).

2. For Health Care Professionals who work at Hunt Regional Medical Center, the guidelines issued by the CDC on July 17, 2020 will be followed as written if the Health Care Professionals' return to work is managed by a licensed practitioner appointed by the Hunt Regional Medical Center.

3. In all other respects, the guidelines issued by the CDC on July 17, 2020 and on July 22, 2020 will be followed as written.

4. While the attached CDC guidelines are recommendations only, this Order adopts them with the changes listed above and they are legally enforceable.

This Order Regarding Returning to Work for COVID-19 Patients and Close Contacts is issued under my authority as the Local Health Authority for Hunt County, Texas, on this 4th day of August, 2020.



Dr. Gina Rushing

Date

EXHIBIT "A"

DURATION OF ISOLATION AND PRECUATIONS FOR ADULTS WITH COVID-19

Issued by the CDC on July 22, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

MENU >

Duration of Isolation and Precautions for Adults with COVID-19

Duration of Isolation & Precautions for Adults

Updated July 22, 2020 Print

Accumulating evidence supports ending isolation and precautions for persons with COVID-19 using a symptom-based strategy. This update incorporates recent evidence to inform the duration of isolation and precautions recommended to prevent transmission of SARS-CoV-2 to others, while limiting unnecessary prolonged isolation and unnecessary use of laboratory testing resources.

Key findings are summarized here.

1. Concentrations of SARS-CoV-2 RNA measured in upper respiratory specimens decline after onset of symptoms (CDC, unpublished data, 2020; Midgley et al., 2020; Young et al., 2020; Zou et al., 2020; Wölfel et al., 2020; van Kampen et al., 2020).
2. The likelihood of recovering replication-competent virus also declines after onset of symptoms. For patients with mild to moderate COVID-19, replication-competent virus has not been recovered after 10 days following symptom onset (CDC, unpublished data, 2020; Wölfel et al., 2020; Arons et al., 2020; Bullard et al., 2020; Lu et al., 2020; personal communication with Young et al., 2020; Korea CDC, 2020). Recovery of replication-competent virus between 10 and 20 days after symptom onset has been documented in some persons with severe COVID-19 that, in some cases, was complicated by immunocompromised state (van Kampen et al., 2020). However, in this series of patients, it was estimated that 88% and 95% of their specimens no longer yielded replication-competent virus after 10 and 15 days, respectively, following symptom onset.
3. A large contact tracing study demonstrated that high-risk household and hospital contacts did not develop infection if their exposure to a case patient started 6 days or more after the case patient's illness onset (Cheng et al., 2020).
4. Although replication-competent virus was not isolated 3 weeks after symptom onset, recovered patients can continue to have SARS-CoV-2 RNA detected in their upper respiratory specimens for up to 12 weeks (Korea CDC, 2020; Li et al., 2020; Xiao et al, 2020). Investigation of 285 "persistently positive" persons, which included 126 persons who had developed recurrent symptoms, found no secondary infections among 790 contacts attributable to contact with these case patients. Efforts to isolate replication-competent virus from 108 of these case patients were unsuccessful (Korea CDC, 2020).
5. Specimens from patients who recovered from an initial COVID-19 illness and subsequently developed new symptoms and retested positive by RT-PCR did not have replication-competent virus detected (Korea CDC, 2020; Lu et al., 2020). The risk of reinfection may be lower in the first 3 months after initial infection, based on limited evidence from another betacoronavirus (HCoV-OC43), the genus to which SARS-CoV-2 belongs (Kiyuka et al, 2018).
6. Currently, 6 months after the emergence of SARS-CoV-2, there have been no confirmed cases of SARS-CoV-2 reinfection. However, the number of areas where sustained infection pressure has been maintained, and therefore reinfections would be most likely observed, remains limited.
7. Serologic or other correlates of immunity have not yet been established.

The current evidence includes the following caveats:

- In a recent study of skilled nursing facility workers followed prospectively for asymptomatic infection, one of 48 infected staff had a nasopharyngeal swab which was weakly positive on a single-passage plaque assay more than 20 days after initial diagnosis; however, the specimen was not subjected to serial passage to demonstrate the presence of replication-competent virus (Quicke et al., 2020).

- In one case report, a person with mild illness provided specimens that yielded replication-competent virus for up to 18 days after symptom onset (Liu et al., 2020).
- Data currently available are derived from adults; equivalent data from children and infants are not presently available.
- More data are needed concerning viral shedding in some situations, including in immunocompromised persons.

Assessment

Available data indicate that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset. Persons with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset. Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, albeit at concentrations considerably lower than during illness, in ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely. The etiology of this persistently detectable SARS-CoV-2 RNA has yet to be determined. Studies have not found evidence that clinically recovered persons with persistence of viral RNA have transmitted SARS-CoV-2 to others. These findings strengthen the justification for relying on a symptom based, rather than test-based strategy for ending isolation of these patients, so that persons who are by current evidence no longer infectious are not kept unnecessarily isolated and excluded from work or other responsibilities.

Reinfection with SARS-CoV-2 has not yet been definitively confirmed in any recovered persons to date. If, and if so when, persons can be reinfected with SARS-CoV-2 remains unknown and is a subject of investigation. Persons infected with related endemic human betacoronavirus appear to become susceptible again at around 90 days after onset of infection. Thus, for persons recovered from SARS-CoV-2 infection, a positive PCR during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.

- If such a person remains *asymptomatic* during this 90-day period, then any re-testing is unlikely to yield useful information, even if the person had close contact with an infected person.
- If such a person becomes *symptomatic* during this 90-day period and an evaluation fails to identify a diagnosis other than SARS-CoV-2 infection (e.g., influenza), then the person may warrant evaluation for SARS-CoV-2 reinfection in consultation with an infectious disease or infection control expert. Isolation may be warranted during this evaluation, particularly if symptoms developed after close contact with an infected person.

Correlates of immunity to SARS-CoV-2 infection have not been established. Specifically, the utility of serologic testing to establish the absence or presence of infection or reinfection remains undefined.

The recommendations below are based on the best information available in mid-July 2020 and reflect the realities of an evolving pandemic. Even for pathogens for which many years of data are available, it may not be possible to establish recommendations that ensure 100% of persons who are shedding replication-competent virus remain isolated. CDC will continue to closely monitor the evolving science for information that would warrant reconsideration of these recommendations.

Recommendations

1. Duration of isolation and precautions
    - For most persons with COVID-19 illness, isolation and precautions can generally be discontinued 10 days *after symptom onset*[1] and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms.
        - A limited number of persons with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; consider consultation with infection control experts.
    - For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days *after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.*
2. Role of PCR testing[2] to discontinue isolation or precautions
    - For persons who are severely immunocompromised, a test-based strategy could be considered in consultation with infectious diseases experts.
    - For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strategy outlined in Part 1, above.
3. Role of PCR testing[2] after discontinuation of isolation or precautions

- For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection.
- For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended. Isolation may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.
- For persons who never developed symptoms, the date of first positive RT-PCR test for SARS-CoV-2 RNA should be used in place of the date of symptom onset.

4. Role of serologic testing
   - Serologic testing should not be used to establish the presence or absence of SARS-CoV-2 infection or reinfection.

[1] *Symptom onset* is defined as the date on which symptoms first began, including non-respiratory symptoms.

[2] *PCR testing* is defined as the use of an RT-PCR assay to detect the presence of SARS-CoV-2 RNA..

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Figure 1: From Wölfel *et al.,* demonstrating declining viral burden in upper respiratory specimens as illness progresses and decreasing capacity to isolate replication-competent virus from these same specimens as the number of patients with detectable IgM and IgG increases.

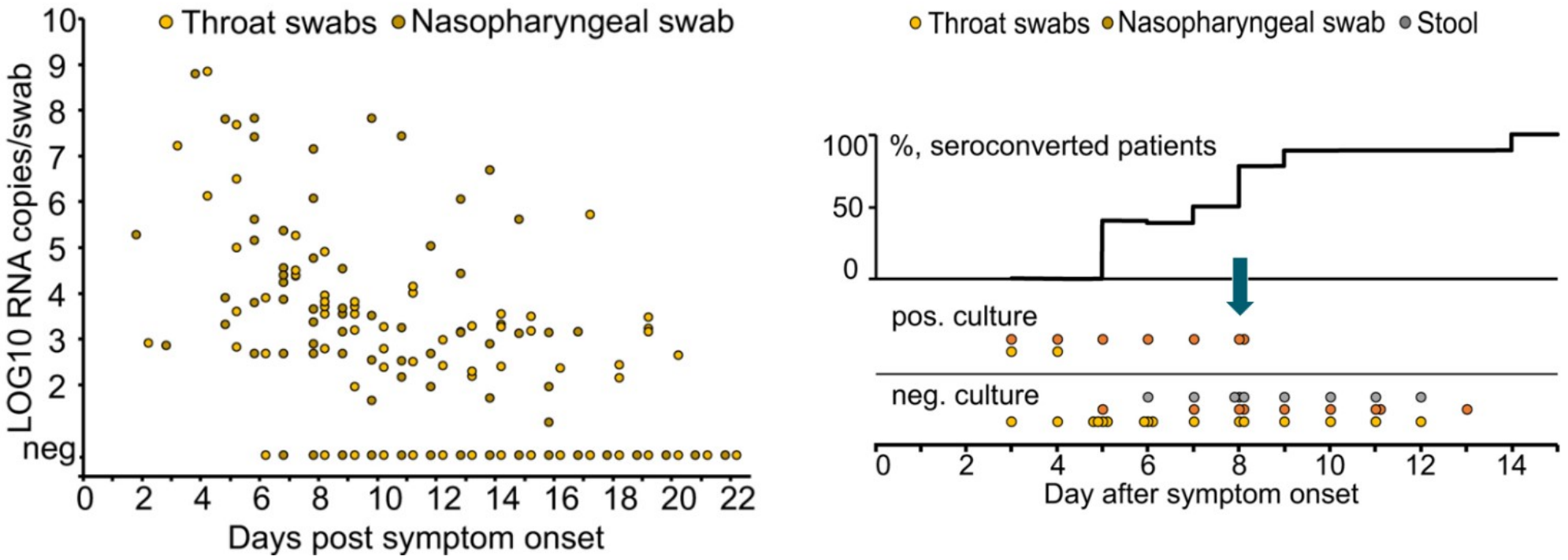


Figure 2: From Midgley *et al.,* demonstrating inability to recover replication-competent virus from specimens collected more than 9 days after illness onset. Kaplan-Meier analysis shows time to inability to recover replication-competent SARS-CoV-2 from 14 U.S. patients. Last probability of successful isolation falls to 50% at day 4 after illness onset and to 80% at day 8. After day 9, probability approaches zero. Unpublished CDC data.

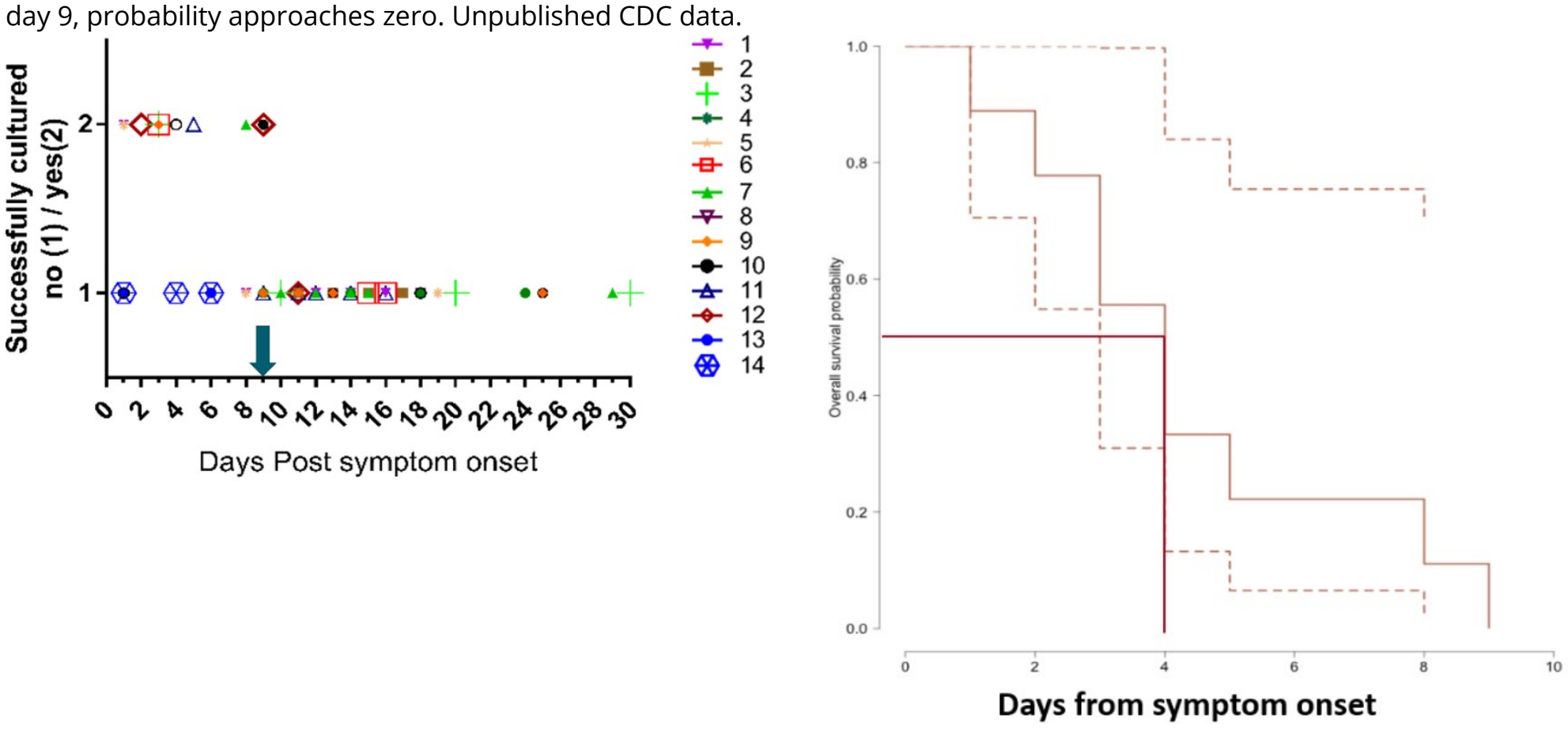


Figure 3. From van Kampen *et al*., demonstrating declining viral RNA loads (Log_{10} RNA copies/mL) and likelihood of positive viral culture for SARS-CoV-2 in the upper respiratory samples from a sample of severely ill patients, including some post -solid organ or -bone marrow transplant. Black boxes represent samples that yielded replication-competent virus.

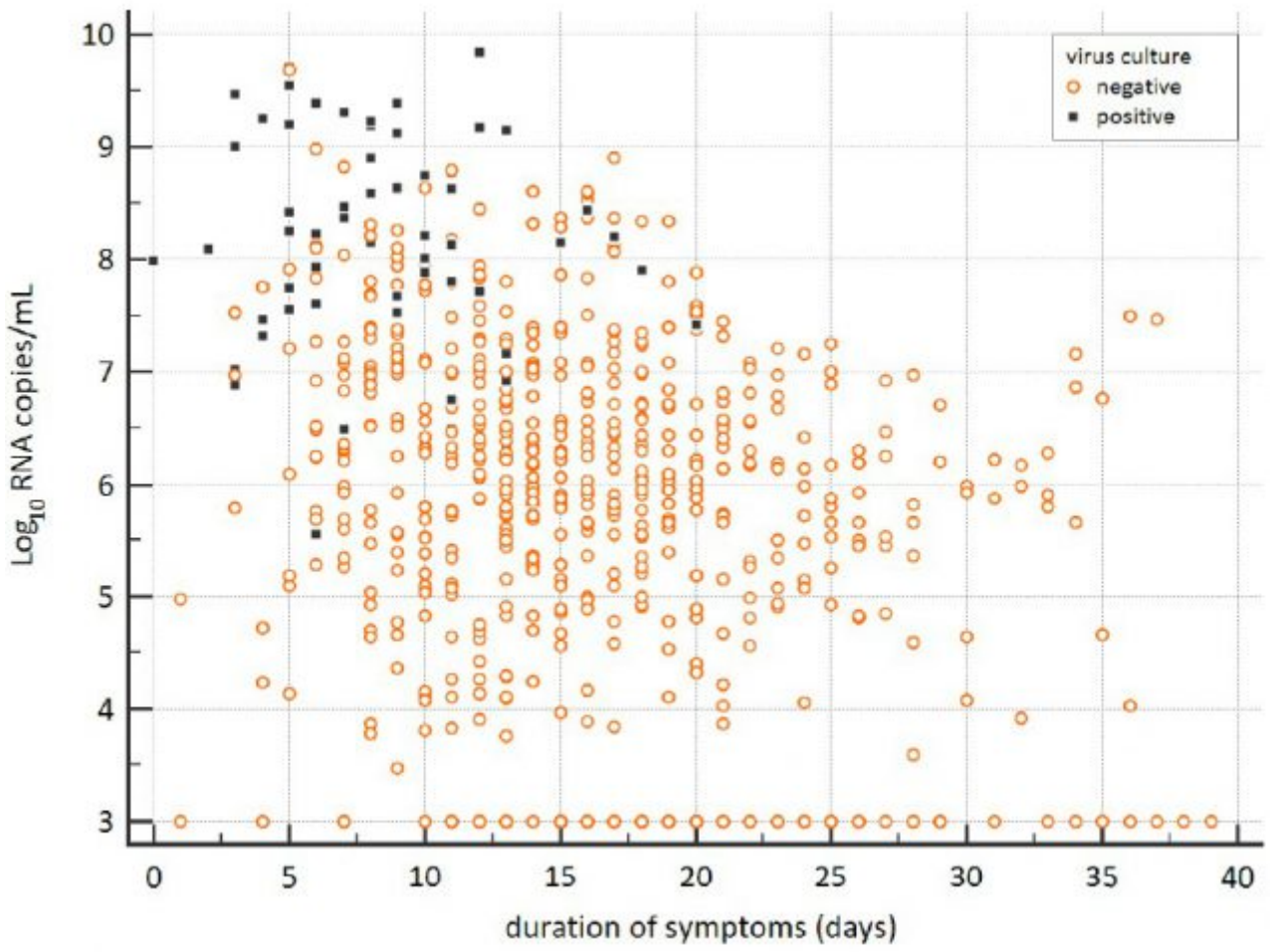


Figure 4. From van Kampen *et al.*, demonstrating decreasing estimated probability of positive viral culture for SARS-CoV-2 from upper respiratory specimens among severely ill patients with COVID-19 with increasing days since symptom onset (upper panel) and decreasing viral load as measured by RT-PCR on the same specimens (lower panel).

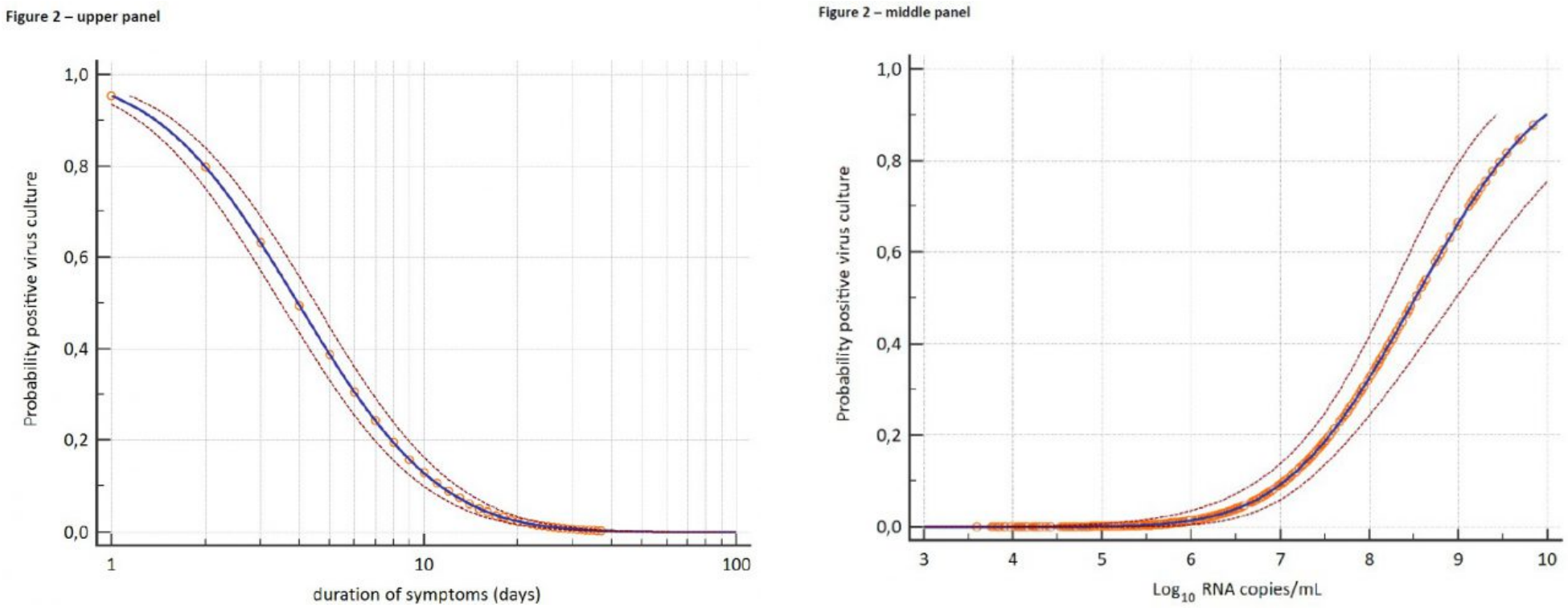


Figure 5. CDC unpublished data showing median Ct values and their 95% confidence intervals among specimens from which replication-competent virus was recovered and not recovered according to the Ct value for the amplification target (N1, N2, or N3) in the CDC RT-PCR assay. RNP = human RNase P, a positive control for the presence of adequate human sample. Red dots indicate specimens with inconclusive RT-PCR amplification according to their corresponding Ct values and culture results.

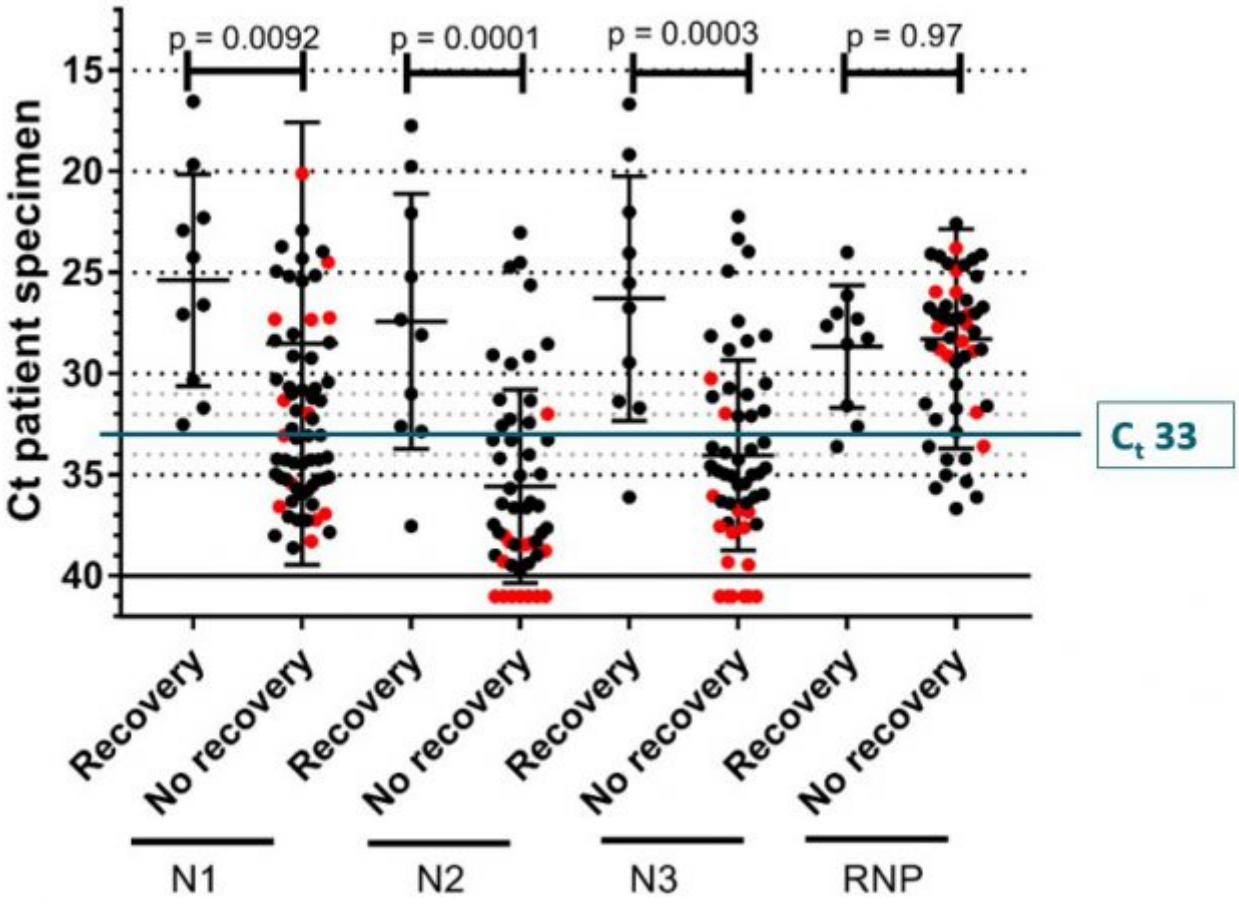
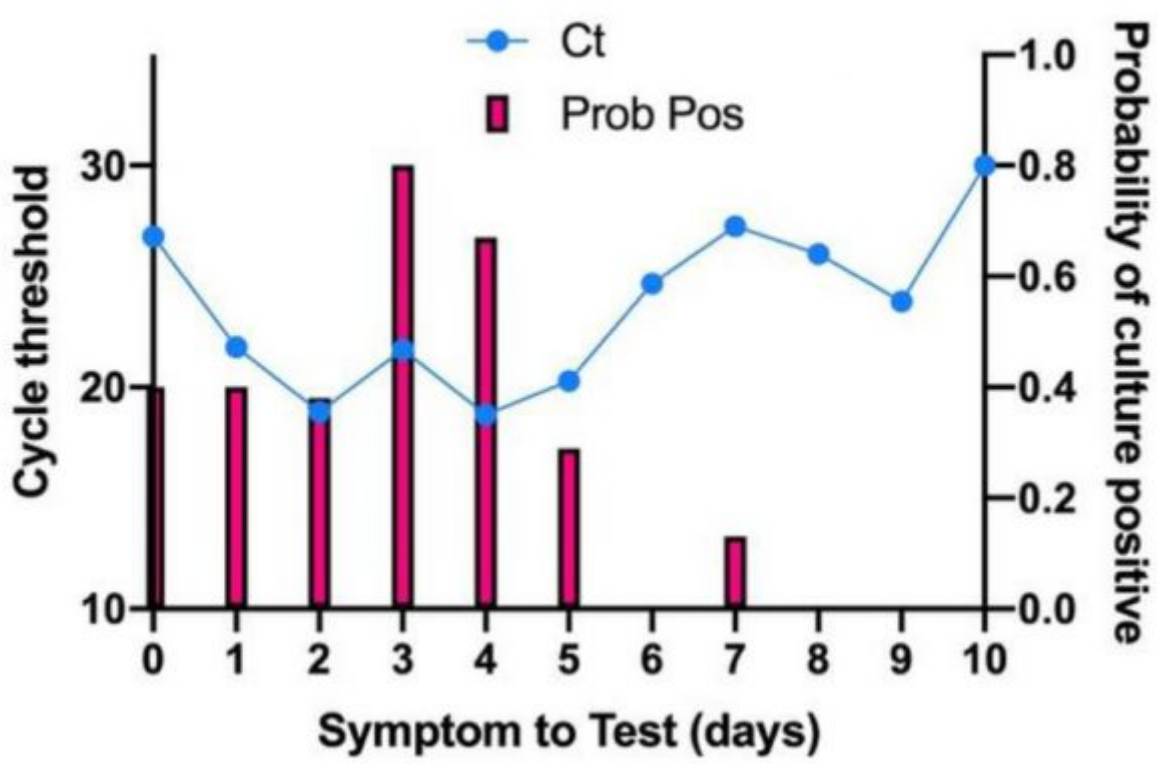


Figure 6. From Bullard *et al.*, comparing symptom onset to test (days) to the probability of successful culture on Vero cells (bar graph) and SARS-CoV-2 E gene RT-PCR cycle threshold (Ct) value (line graph).



Last Updated July 22, 2020

EXHIBIT "B"

CRITERIA FOR RETURN TO WORK FOR HEALTHCARE PERSONNEL WITH SARS-CoV-2 INFECTION (INTERIM GUIDANCE)

Issued by the CDC July 17, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

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Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance) Return-to-Work Criteria

Updated July 17, 2020 Print

Summary of Recent Changes as of July 17, 2020

- Except for rare situations, a test-based strategy is no longer recommended to determine when to allow HCP to return to work.
- For HCP with severe to critical illness or who are severely immunocompromised[1], the recommended duration for work exclusion was extended to 20 days after symptom onset (or, for asymptomatic severely immunocompromised[1] HCP, 20 days after their initial positive SARS-CoV-2 diagnostic test).

- Other symptom-based criteria were modified as follows:
  - Changed from "at least 72 hours" to "at least 24 hours" have passed *since last* fever without the use of fever-reducing medications
  - Changed from "improvement in respiratory symptoms" to "improvement in symptoms" to address expanding list of symptoms associated with COVID-19

- A summary of current evidence and rationale for these changes is described in a Decision Memo.

CDC guidance for SARS-CoV-2 infection may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Who this is for: Occupational health programs and public health officials making decisions about return to work for healthcare personnel (HCP) with confirmed SARS-CoV-2 infection, or who have suspected SARS-CoV-2 infection (e.g., developed symptoms of COVID-19) **but were never tested for SARS-CoV-2**.

HCP with symptoms of COVID-19 should be prioritized for viral testing with approved nucleic acid or antigen detection assays. When a clinician decides that testing a person for SARS CoV-2 is indicated, negative results from at least one FDA Emergency Use Authorized COVID-19 molecular viral assay for detection of SARS-CoV-2 RNA indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 RNA may be performed at the discretion of the evaluating healthcare provider, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists. For HCP who were suspected of having COVID-19 and had it ruled out, either with at least one negative test or a clinical decision that COVID-19 is not suspected and testing is not indicated, then return to work decisions should be based on their other suspected or confirmed diagnoses.

Decisions about return to work for HCP with SARS-CoV-2 infection should be made in the context of local circumstances. In general, a symptom-based strategy should be used as described below. The time period used depends on the HCP's severity of illness and if they are severely immunocompromised.[1]

A test-based strategy is no longer recommended (except as noted below) because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Other Resources:

For guidance about assessment of risk and application of work restrictions for asymptomatic healthcare personnel (HCP) with potential exposure to patients, visitors, or other HCP with confirmed COVID-19, refer to the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19.

Return to Work Criteria for HCP with SARS-CoV-2 Infection

Symptom-based strategy for determining when HCP can return to work.

HCP with mild to moderate illness who are not severely immunocompromised:

- At least 10 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

Note: HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

HCP with severe to critical illness or who are severely immunocompromised[1]:

- At least 20 days have passed *since symptoms first appeared*
- 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

Note: HCP who are **severely immunocompromised**[1] but who were **asymptomatic** throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.

As described in the Decision Memo, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, the more conservative period of 20 days was applied in this guidance. However, because the majority of severely or critically ill patients no longer appear to be infectious 10 to 15 days after onset of symptoms, facilities operating under critical staffing shortages might choose to allow HCP to return to work after 10 to 15 days, instead of 20 days.

Test-Based Strategy for Determining when HCP Can Return to Work.

In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised[1]) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

The criteria for the test-based strategy are:

HCP who are symptomatic:

- 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 ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

HCP who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV)

Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information.

Definitions

Cloth face covering: Textile (cloth) covers are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE, and it is uncertain whether cloth face coverings protect the wearer.** CDC has guidance available on design, use, and maintenance of cloth face coverings.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

SARS-CoV-2 Illness Severity Criteria (adapted from the NIH COVID-19 Treatment Guidelines):

Note: The studies used to inform this guidance did not clearly define "severe" or "critical" illness. This guidance has taken a conservative approach to define these categories. Although not developed to inform decisions about when HCP with SARS-CoV-2 infection may return to work, the definitions in the National Institutes of Health (NIH) COVID-19 Treatment Guidelines are one option for defining severity of illness categories. The highest level of illness severity experienced by the HCP at any point in their clinical course should be used when determining when they may return to work.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction

Critical illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Footnotes

[1]The studies used to inform this guidance did not clearly define “severely immunocompromised”. For the purposes of this guidance, CDC used the following definition that was created to more generally address HCP occupational exposures.

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and require actions such as lengthening the duration of HCP work restrictions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect occupational health actions to prevent disease transmission.
- Ultimately, the degree of immunocompromise for HCP is determined by the treating provider, and preventive actions are tailored to each individual and situation.

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