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TO:	CAL-MAT Members
FROM:	Dave Duncan, MD Director Howard Backer, MD CAL-MAT Medical Director
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SUBJECT: CAL-MAT COVID-19 Isolation, symptom management, notification, and return to work

PURPOSE:
Management of CAL-MAT members who develop symptoms of illness while on deployment

Summary and New information

- Guidance for management of healthcare workers (HCWs) who are exposed to COVID 19 or become symptomatic or test positive without symptoms (updated by CDC 7/17/20)
- Notification made to EMSA Medical Director and to HR via automated reporting form
- CAL-MAT unit leader should be notified but no medical information unless consent
- Workers Compensation management by HR
- Determination of exposure risk for health care workers and their work colleagues and return to work based on CDC guidance
- Procedure for RTW or demobilization

Purpose

Protecting the health and safety of our personnel is a top priority. To support this goal, EMSA has adopted the CDC guidelines for infection control and the use of Personal Protection Equipment (PPE) when treating COVID-19 patients. Additionally, EMSA works diligently to assure an adequate supply of recommended PPE and that infection control and PPE training occurs at each treatment site EMSA supports with CAL-MAT members.

EMSA recognizes that there is still a possibility that a CAL-MAT member will contract COVID-19 while supporting the response. Moreover, due to the unusual nature of response teams in the field, there is a high probability that co-workers will be exposed when a colleague develops symptoms and becomes a Person under Investigation (PUI) or tests positive for COVID19.

The following protocols apply to all deployed personnel.

Policy/Procedure

A. Pre-deployment

1. Routine pre-deployment COVID 19 testing is not required or recommended.
2. No pre-deployment physical exam is required for CAL-MAT members. They are expected to self-select with informed knowledge of work conditions and job description

B. Development of clinical symptoms during COVID

1. Any member who develops a temperature higher than 100 F or has symptoms of cough, shortness of breath, fever, chills, muscle pain, sore throat, or new loss of taste or smell must report their illness to the Team Lead and isolate themselves in their hotel room.

C. Testing

1. COVID testing will be conducted on-site, when available. If on-site testing is unavailable, testing will be arranged with the closest County testing site or other test site. The isolated member may be tested at a nearby ED if the need for further medical evaluation is indicated.

D. Isolation

1. The decision to continue isolation and further testing of the member for COVID 19 shall be made by the on-site Medical Officer, if available, or by the CAL-MAT or EMS Authority Medical Director.
2. While isolated, staff must record and report temperature twice a day and any change in symptoms via phone to the CAL-MAT Team lead or provider on-call.
3. The medical provider on-call will evaluate symptoms at least once daily.
4. Logistics will arrange to have meals and any needed medications delivered.

E. Notification

1. The MST Director/Team Lead shall notify the CALMAT medical director and EMSA HR of any occupational infection or injury. This is be done using a form stack report, which automatically forwards the completed form.
2. Initial reporting form: **https://EMSADMS.formstack.com/forms/exposure_report**
3. Follow-Up reporting form: **https://EMSADMS.formstack.com/forms/exposure_report_copy**

4. When a CAL-MAT member is taken off shift for illness or injury, the Unit Leader (if known) should be informed; no waiver is required as long as specific medical information is not shared. The member may provide medical information (e.g., COVID test results or specific diagnosis) to the Unit Leader if they choose.

F. Worker's Compensation

1. CAL-MAT members are eligible to receive Worker's Compensation insurance while employed by the State.
2. Once the Team Lead completes the forms above, **EMSA HR** will take the following action in compliance with Worker's Compensation rules:
    a. Facilitate referral to an occupational health provider if needed
    b. Send the e3301 to the employee and will follow up with the employee to receive it.
    c. Coordinate emergency paid sick leave with both the employee and with State Compensation Insurance Fund (SCIF) in accordance with workers comp policies.
    d. Work with the employee on time sheet submittal upon demobilization or when the SCIF medical provider releases the employee to return to work.
3. Any CAL-MAT member isolated while supporting the EMSA COVID-19 response will receive 8 hours of pay daily until cleared from isolation.
4. CAL-MAT members should not be demobilized while in isolation or being treated for illness. If they do not plan to continue their deployment, members should be demobilized when they are no longer ill and the isolation period is completed.
5. If a member has demobilized and wishes to quarantine for 14 days to avoid potential exposure of family or other household members, they may use the State program to quarantine in a hotel. This program can be accessed at https://covid19.ca.gov/hotel-rooms-for-california-healthcare-workers/
6. If a member has demobilized and subsequently develops symptoms within the quarantine period, they should notify their site leader who will notify HR through the report of illness and assist to arrange testing, if the CAL-MAT member is still near the site.
    a. If the member has left to return home, the member should arrange testing locally. This may be done through the state occupational medicine provider network.
    b. If the test is positive, the member is eligible for workers compensation during the period of illness and subsequent isolation.

G. Return to Work or Demobilization

1. If the test comes back negative and the symptoms continue to diminish, the individual may return to work 2 days after all symptoms have resolved, consistent with the

diagnosis and judgment of the site Chief Medical Officer, or the CAL-MAT Program Medical Director. If symptoms have not resolved, or there remains high concern for COVID, the member should be retested at least 24 hours after the first test.

2. If the test comes back positive, the member should have the option to remain isolated in a hotel through the health care worker isolation program or to self-isolate at home.
3. EMSA will arrange transport home, to a hospital for evaluation, or to another isolation facility.
    a. All team members who had close, prolonged contact without PPE (See CDC definitions) with the positive member within two days of symptom onset should quarantine and receive testing. CDC guidelines also allows potentially exposed asymptomatic HCWs to continue work in settings of HCW shortage.
4. The team members who had contact while wearing PPE or contact that does not meet the definition of "close and prolonged", may continue working with appropriate PPE following CDC PPE/infection control protocols, unless they develop symptoms. They must continue to take precautions, including face mask use and social distancing around their colleagues and the public.
5. All potentially exposed members must (as should all members) wear a facemask at all times outside of the patient care area and maintain appropriate social distancing from their colleagues for 14 days. According to the State Public Health Officer Order, facemasks may be removed when eating, exercising, or not in proximity to others, but social distancing must be maintained.
6. Employees should not be released back to work without notifying HR. This is an important step so that HR has this information for the State Compensation Insurance Fund and possibly DGS
7. All employees need a medical release from the CAL-MAT Program Medical Director or the Chief Medical Officer on site whether they:
    a. Return to the mission site (whether after testing negative or positive), or
    b. Demobilize from site and from mission

A work release template is available on-line (Sharepoint: *Documents/CAL-MAT Medical/Policy Procedures/RTW release*)

8. The medical release that allows the employee to return to work will be forwarded by email to HR so that the file can be documented accordingly.

H. Preventing cross-exposure among CALMAT members

1. During the COVID 19 response, CAL-MAT members provide healthcare in a high-risk infectious environment. Many infections are asymptomatic or can be spread for 2 days prior to symptoms.
2. To avoid spreading possible infection to colleagues, CAL-MAT members must follow public infection control recommendations when outside of a health facility.

3. This includes wearing a surgical or cloth mask when appropriate social distancing is not possible. This is especially important when multiple members are riding in the same vehicle or when socializing after work.
4. Changing out of work clothes and performing frequent hand hygiene are other important measures.

Resources, Links, and Attachments (below)

Supporting CDC Guidance

Determination of exposure risk for health care personnel

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

Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Strategies to Mitigate Healthcare Personnel Staffing Shortages

https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Supporting CDC Guidance

Determination of exposure risk for health care personnel

This guidance applies to HCP with potential exposure in a healthcare setting to patients, visitors, or other HCP with confirmed COVID-19. Exposures can also be from a person under investigation (PUI) who is awaiting testing. Work restrictions described in this guidance might be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. Therefore, a record of HCP exposed to PUIs should be maintained. If test results will be delayed more than 72 hours or the patient is positive for COVID-19, then the work restrictions described in this document should be applied.

Exposure	Personal Protective Equipment Used	Work Restrictions
HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed COVID-19[3]	• HCP not wearing a respirator or facemask[4] • HCP not wearing eye protection • HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure	• Exclude from work for 14 days after last exposure[5] • Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19[6] • Any HCP who develop fever or symptoms consistent with COVID-19[6] should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
HCP other than those with exposure risk described above	• N/A	• No work restrictions • Follow all recommended infection prevention and control practices, including wearing a facemask for source control while at work, monitoring themselves for fever or symptoms consistent with COVID-19[6] and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19[6] at the beginning of their shift. • Any HCP who develop fever or symptoms consistent with COVID-19[6] should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

HCP=healthcare personnel

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. However, **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 COVID-19 or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.

Supporting CDC Guidance

3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 could have been infectious:

    a. 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

    b. For individuals with confirmed COVID-19 who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with COVID-19 may have been exposed could help inform the period when they were infectious.

        1. In general, individuals with COVID-19 should be considered potentially infectious beginning 2 days after their exposure until they meet criteria for discontinuing Transmission-Based Precautions.
        2. 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 dayspdf icon prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.

4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into this risk assessment. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown.

5. If staffing shortages occur, it might not be possible to exclude exposed HCP from work. For additional information and considerations refer to Strategies to Mitigating HCP Staffing Shortages.

*For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0°F (37.8°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDS]).

Supporting CDC Guidance

Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

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.

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**[1] 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.

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).

If HCP are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all Return to Work Criteria Prioritizing HCP with suspected COVID-19 for testing, as testing results will impact when they may return to work and for which patients they might be permitted to provide care.

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 higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

Strategies to Mitigate Healthcare Personnel Staffing Shortages

While not ideal, in situations of critical staffing shortages some facilities have conferred with the local public health authorities and allowed HCWs with suspected or confirmed COVID-19 to return to work earlier than indicated in the recommended return to work strategies. This has been determined on a case-by-case basis, and facilities have considered duty restrictions, such as only permitting infected HCWs to care for patients with COVID-19 or limiting them to non-patient care activities.
(See Return to Work Diagram)

Asymptomatic HCP with a recognized COVID-19 exposure might be permitted to work in a crisis capacity strategy to address staffing shortages if they wear a facemask for source control for 14 days after the exposure. This time period is based on the current incubation period for COVID-19 which is 14 days.

Developing plans to allow asymptomatic HCP who have had an unprotected exposure to SARS-CoV-2 (the virus that causes COVID-19) but are not known to be infected to continue to work.

- These HCP should still report temperature and absence of symptoms each day before starting work. These HCP should wear a facemask (for source control) while at work for 14 days (this is the time period during which exposed HCP might develop symptoms, i.e., the current incubation period for the virus) after the exposure event. 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 higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19.

- If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.