

## Health Update:

### Criteria to Guide Evaluation and Laboratory Testing for COVID-19

**March 24, 2020**

This document will be updated as new information becomes available. The current version can always be viewed at <http://www.health.mo.gov>.

The Missouri Department of Health & Senior Services (DHSS) is now using four types of documents to provide important information to medical and public health professionals, and to other interested persons:

**Health Alerts** convey information of the highest level of importance which warrants immediate action or attention from Missouri health providers, emergency responders, public health agencies or the public.

**Health Advisories** provide important information for a specific incident or situation, including that impacting neighboring states; may not require immediate action.

**Health Guidances** contain comprehensive information pertaining to a particular disease or condition, and include recommendations, guidelines, etc. endorsed by DHSS.

**Health Updates** provide new or updated information on an incident or situation; can also provide information to update a previously sent Health Alert, Health Advisory, or Health Guidance; unlikely to require immediate action.

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**Health Update**  
**March 24, 2020**

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**SUBJECT: Update: Criteria to Guide Evaluation and Laboratory Testing for COVID-19 (updates underlined)**

Issued March 22, 2020

### Summary

Testing for COVID-19 is available through the Missouri State Public Health Laboratory (SPHL) as well as commercial clinical laboratories. Clinicians who wish to submit specimens to the SPHL must submit a Missouri Patient Under Investigation (PUI) and Case Report Form and a Virology Test Request **for each approved patient**. For more information and to access the forms, please visit the SPHL Novel Coronavirus webpage at <https://health.mo.gov/lab/ncov.php>. COVID-19 testing for asymptomatic individuals through any laboratory is not recommended. To request testing through the SPHL, providers should call the Department of Health and Senior Services Hotline at 877-435-8411.

Clinicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever<sup>1</sup> and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). Priorities for testing may include:

1. Hospitalized patients who have signs and symptoms compatible with COVID-19 in order to inform decisions related to infection control.
2. Symptomatic residents of congregate living facilities that house adults ages 65 or older and individuals with chronic medical conditions and/or an immunocompromised state that may put them at higher risk for poor outcomes (e.g., diabetes, chronic heart disease, such as heart failure, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).
3. Any persons including healthcare personnel<sup>2</sup>, who within 14 days of symptom onset had close contact<sup>3</sup> with a suspect COVID-19 patient with pending laboratory testing or laboratory-confirmed<sup>4</sup> COVID-19 patient.

There are epidemiologic factors that may also help guide decisions about COVID-19 testing. Documented COVID-19 infections in a jurisdiction and known community transmission may contribute to an epidemiologic risk assessment to inform testing decisions. Clinicians are strongly encouraged to test for other causes of respiratory illness (e.g., influenza).

Mildly ill patients should be encouraged to stay home and contact their healthcare provider by phone for guidance about clinical management. Patients who have severe symptoms, such as difficulty breathing, should seek care immediately. Older patients and individuals who have underlying medical conditions or are immunocompromised should contact their physician early in the course of even mild illness.

**FOR PERSONS with COVID-19 UNDER HOME ISOLATION:**

The decision to discontinue home isolation should be made in the context of local circumstances. Options now include both 1) a time-since-illness-onset and time-since-recovery (non-test-based) strategy, and 2) a test-based strategy.

Time-since-illness-onset and time-since-recovery strategy (non-test-based strategy) - Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue home isolation under the following conditions:

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 7 days have passed *since symptoms first appeared*.

This recommendation will prevent most, but may not prevent all instances of secondary spread. The risk of transmission after recovery, is likely very substantially less than that during illness.

Previous recommendations for a test-based strategy remain applicable; however, a test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing.

Individuals with laboratory-confirmed COVID-19 who have not had any symptoms may discontinue home isolation when at least 7 days have passed since the date of their first positive COVID-19 diagnostic test and have had no subsequent illness.

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

Two recommended options are listed below for healthcare facilities that have employees returning to work after COVID-19 illness.

1. Non-test-based strategy. Exclude from work until:
  - a. At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - b. At least 7 days have passed *since symptoms first appeared*.
2. Test-based strategy. Exclude from work until:
  - a. Resolution of fever without the use of fever-reducing medications **and**
  - b. Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - c. Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected  $\geq 24$  hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

If HCP were never tested for COVID-19 but have an alternative diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

## Return to Work Practices and Work Restrictions

After returning to work, HCP should:

- Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

<sup>1</sup> Fever may be subjective or confirmed.

<sup>2</sup> For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 \(COVID-19\)](#).

<sup>3</sup> Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Additional information is available in CDC's updated [Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings](#).

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk as does exposure to a severely ill patient). Special consideration should be given to healthcare personnel exposed in healthcare settings as described in CDC's [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19](#).

<sup>4</sup> Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.