Interim Guidance for Management of Healthcare Personnel with Suspect or Confirmed Viral Respiratory Illness (Including COVID-19, Influenza and Other Acute Respiratory Infections)

September 2025

This evidence based interim guidance reflects recommendations presented by the Healthcare Infection Control Practices Advisory Committee (HICPAC) on November 24, 2024.

It replaces the previous guidance specific to healthcare personnel (HCP) with SARS-CoV-2 infection or exposure and now applies more broadly to HCP with suspected or confirmed SARS-CoV-2, seasonal influenza, and other acute viral respiratory infections—regardless of whether diagnostic testing is conducted or its results.

This guidance does not apply to infections caused by novel influenza A viruses (including H5N1), Middle East Respiratory Syndrome (MERS), or other pathogens for which specific public health guidance exists.

Work exclusion and source control remain key strategies to reduce transmission in healthcare settings. Additional infection prevention and control measures, in addition to vaccination, are outlined in CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings.

For questions about this information, contact ahs.vdhhaiepi@vermont.gov.

Recommendation 1: Personnel with Suspected or Confirmed Infection**

- For healthcare personnel with suspected* or confirmed viral respiratory infection not specifically addressed elsewhere in public guidance:
  - Restrict from work until:
    - Three days have passed since symptom onset (or from their first positive respiratory virus test if asymptomatic throughout their infection. Day 0 represents symptom onset or positive test, whichever came first),

      AND
    - They are fever-free for at least 24 hours without the use of antipyretics,

      AND
    - Symptoms are improving,

      AND
    - They feel well enough to return to work.

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- Wear source control upon return to work until the end of day 7, where the first day of symptoms (of first positive test if asymptomatic throughout their infection) is day 0.

*For the purpose of this guidance, **suspected viral respiratory infection** is defined as the presence of two or more signs or symptoms such as fever, cough, rhinorrhea, malaise, nasal congestion, or sore throat. This guidance is not applicable for HCP with non-infectious conditions that cause similar symptoms (e.g., seasonal allergies, asthma, chronic obstructive pulmonary disease).

HCP with respiratory viral infections who are **moderately or severely immunocompromised** might shed virus for prolonged periods. If available, consider consultation with an occupational health specialist, an infectious disease specialist or other relevant expert to determine when these HCP may return to work and discontinue use of source control. Additionally, using a test-based strategy can aid in making this determination.

See Table 1 for more information on moderate to severe immunocompromise.

** There may be certain situations during an outbreak that require additional consultation with the Health Department to determine work exclusion criteria.

Recommendation 2: Asymptomatic Personnel with a Known or Suspected Exposure

- For asymptomatic healthcare personnel who have a known or suspected exposure to a respiratory virus not specifically addressed elsewhere in public health guidance:
  - Work restrictions are not necessary.
  - Wear source control from the day of first exposure through the fifth day after their last exposure.*
  - Monitor for development of signs or symptoms of a viral respiratory infection for five days after their last exposure.
    - Any HCP who develops signs or symptoms of a viral respiratory infection should be restricted from work as described in Recommendation 1.

Key Definitions

Healthcare Personnel (HCP): For the purposes of this guidance, HCP refers to all persons, paid and unpaid, working in healthcare settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP include, but are not limited to: physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists,

laboratory personnel, autopsy personnel, students and trainees, contractual personnel, home healthcare personnel, and persons not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients (e.g., clerical, dietary, house-keeping, laundry, security, maintenance, billing, chaplains, and volunteers).

Healthcare Setting: For the purposes of this guidance, healthcare settings include, but are not limited to, acute-care hospitals; long-term acute care hospitals; long-term care facilities, such as nursing homes and skilled nursing facilities; physicians' offices; urgent-care centers, outpatient clinics (including dental clinics and dialysis clinics); and home healthcare.

Source Control: "Source Control" refers to the use of well-fitting masks or respirators to cover the wearer's mouth and nose to prevent spread of their respiratory secretions to others when they are breathing, talking, sneezing, or coughing. Masks and respirators also offer varying types and levels of protection to the wearer.

Common source control device options for HCP include, but are not limited to:

- A NIOSH Approved® N95® filtering facepiece respirator.
- A well-fitting surgical mask or procedure mask.

Cloth masks are not typically considered acceptable for use as a source control device in healthcare settings.

Suspected Viral Respiratory Infection: For the purposes of this guidance, suspected viral respiratory infection is defined as the presence of two or more signs or symptoms such as fever, malaise, cough, rhinorrhea, nasal congestion, or sore throat.

Table 1: Moderate to Severe Immunocompromise

Moderate and severe immuno-compromising conditions and treatments include but are not limited to:
Factors to consider in assessing the general level of immune competence in a patient include disease severity, duration, clinical stability, complications, comorbidities, and any potentially immune-suppressing treatment.
• Active treatment for solid tumor and hematologic malignancies
• Hematologic malignancies associated with poor responses to vaccination regardless of current treatment status (e.g. chronic lymphocytic leukemia, non-Hodgkin lymphoma, multiple myeloma, acute leukemia)
• Recipient of solid-organ transplant or an islet transplant and taking immunosuppressive therapy
• Recipient of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppressive therapy)
• Moderate or severe primary immunodeficiency (e.g., common variable immunodeficiency disease, severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome)
• Advanced HIV infection (people with HIV and CD4 cell counts less than 200/mm3. History of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV) or untreated HIV infection
• Active treatment with high-dose corticosteroids (i.e., 20 mg or more of prednisone or equivalent per day when administered for 2 or more weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory (e.g., B-cell-depleting agents)

Resources

- Immunocompromised Travelers | Yellow Book | CDC
- Altered Immunocompetence | Vaccines & Immunizations | CDC
- IDSA 2013 Guideline for Vaccination of the Immunocompromised Host