COVID-19 Primary Healthcare Guidance

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What quarantine measures are required for healthcare workers travelling from higher prevalence areas to low prevalence areas?

Context

- Health care workers (HCWs) are a substantial vector of SARS-CoV-2 (COVID-19).
- Travel from higher prevalence settings to low prevalence settings poses a risk of transmission of SARS-CoV-2 (COVID-19).
- There may be state and territory, regional, local and/or community travel restrictions and requirements that need to be considered.
- Maintaining access to high quality primary health care is critical including during the period of restrictions due to social distancing requirements.

Summary of recommendations

- All alternatives to visiting the lower prevalence area should be explored including:
  - consultations by telehealth
  - remote support to local health staff
  - cancelling non-essential visits.
- If a visit is considered absolutely necessary:
  - HCWs may travel from a higher prevalence area to a lower prevalence area if, in the last 14 days, they:
    - have not travelled overseas; AND
    - have not had fever (≥37.5°C), chills, and/or night sweats; AND
    - have not had acute respiratory infection, including sore throat, cough, or shortness of breath; AND
    - have not had contact with a confirmed COVID-19 case without adequate use of PPE.
  - HCWs who have experienced fever or respiratory symptoms in the last 14 days may enter a lower prevalence area if they:
    - no longer have fever or respiratory symptoms; AND
    - have had a negative PCR test for COVID-19 since the onset of symptoms.

NACCHO National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au
LOWITJA INSTITUTE
RACGP Royal Australian College of General Practitioners
Australian National University

Recommendations and rationale

All alternatives to visiting the community should be explored including:

- **consultations by telehealth**
- **remote support to local health staff**
- **cancelling non-essential visits.**

If there are any feasible alternatives to visiting a lower prevalence area, they should be pursued. All HCWs entering a lower prevalence area from a higher prevalence area are potentially symptomatic or asymptomatic carriers of COVID-19. It is therefore critical in these settings to be ambitious about prevention and minimise transmission risk, despite the additional burden this may place on services.

The median incubation period for SARS-CoV-2 (COVID-19) is estimated at 5 to 6 days (1). Most studies report a maximum incubation period of 14 days. International quarantine policies are based on the 14-day incubation period. However, one case study indicates that the incubation period may be as long as 24 days (2). If the incubation period can be greater than 14 days, an extended quarantine duration may be required to minimise the spread of SARS-CoV-2 (COVID-19) (2).

Based on current best available evidence (3):

- less than 2.5% of infected persons will show symptoms within 2.2 days (Confidence Interval: 1.8 to 2.9 days) of exposure
- around half of infected persons will show symptoms within 5 days – this means half will not show symptoms until after 5 days
- 97.5% of infected persons will show symptoms within 11.5 days (Confidence Interval: 8.2 to 15.6 days)
- among people who are infected and go on to develop symptoms, 101 in 10 000 will develop symptoms after 14 days (i.e. outside of the quarantine period), and this estimate may be conservative.

Given the risks associated with providing care while a symptomatic or asymptomatic carrier of SARS-CoV-2 (COVID-19), **HCWs should only travel from a higher prevalence area to a lower prevalence area if a visit is considered absolutely necessary**. For example, this may include when a health service cannot meet the needs of the community using the combination of available staff providing in-person services and telehealth services by other HCWs, where relevant.

If a visit is considered absolutely necessary:

- **HCWs may travel from a higher prevalence area to a lower prevalence area if, in the last 14 days, they:**
    - **have not travelled overseas; *and***
    - **have not had fever (≥37.5°C), chills, and/or night sweats; AND**
    - **have not had acute respiratory infection, including sore throat, cough, or shortness of breath; *and***
    - **have not had contact with a confirmed COVID-19 case without adequate use of PPE.**

We recommend that when travelling from a higher prevalence area to a lower prevalence area, to be exempted from quarantine, HCWs must not have experienced any of the signs or symptoms of COVID-19 (fever, chills, night sweats, or acute respiratory infection – including sore throat, cough, or shortness of breath) **over the period of 14 days prior to entry**. The rationale for including symptoms over the 14 day period prior to

entry is that, under current guidelines, HCWs should be tested for COVID-19 if they have a fever (≥37.5°C, or history of fever) OR acute respiratory infection (4).

HCWs should be aware of other symptoms of COVID-19 as they are identified. The Centre for Evidence-Based Medicine provides a 'COVID-19 Signs and Symptoms Tracker' that is updated as data emerges (5).

There are currently no guidelines specific to Aboriginal and Torres Strait Islander communities or to Australia on risk assessment on COVID-19 risk after exposure in the health care setting. Until local guidelines are developed, HCWs can assess their risk using the CDC (6) or WHO (7) risk assessment tools.

If a visit is considered absolutely necessary:

- **HCWs who have experienced fever or respiratory symptoms in the last 14 days may enter a remote community if they:**
  - **no longer have fever or respiratory symptoms; *and***
  - **have had a negative PCR test for COVID-19 since the onset of symptoms.**

As above, the Communicable Disease Network Australia (CDNA) COVID-19 guidelines (10) recommend that HCWs be tested for COVID-19 if they have experienced fever or respiratory symptoms. If HCWs have experienced symptoms in the last 14 days but return a negative PCR test for COVID-19 and are no longer symptomatic, they may enter a lower prevalence area, noting that: 'A risk assessment should be undertaken for suspected cases who initially test negative for SARS-CoV-2. If there is no alternative diagnosis and a high index of suspicion remains that such cases may have COVID-19, consideration should be given to continued isolation and use of the recommended infection control precautions, pending further testing' (4).

Related topics and resources

Australian Department of Health guidelines on self-isolation and quarantine

COVID-19 Primary Healthcare guidance What quarantine measures are required for HCWs travelling to remote communities?

Tools for assessing HCW risk of exposure CDC or WHO

The appropriate level of infection control and prevention (ICP) for visiting/returning HCWs who are exempt from quarantine - recommendations under development.

COVID-19 Restriction Checker https://www.healthdirect.gov.au/covid19-restriction-checker/domestic-travel/act

Summary of travel restrictions National Indigenous Australians Agency

State and Territory travel restrictions Queensland NT WA SA NSW

References

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6. Centers for Disease Control and Prevention. 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 (COVID-19) 2020 [updated 7 March 2020].[Available HERE].
7. World Health Organization. Health workers exposure risk assessment and management in the context of COVID-19 virus. 2020. 19 March 2020.

Suggested citation:

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[1] Australian National University

[2] A joint initiative formed between the National Aboriginal Community Controlled Health Organisation, Royal Australian College of General Practitioners and Lowitja Institute. Additional contributors to this guidance included: Expert Reviewers: Atkinson D, Peiris D, and Senior T); an Executive Group Belfrage M, Agostino J, Thurber K, Senior T, Chamberlain C, and Freeman K; and Expert Committee.