Health Care Exposure Risk Assessment and Quarantine Guideline

Background

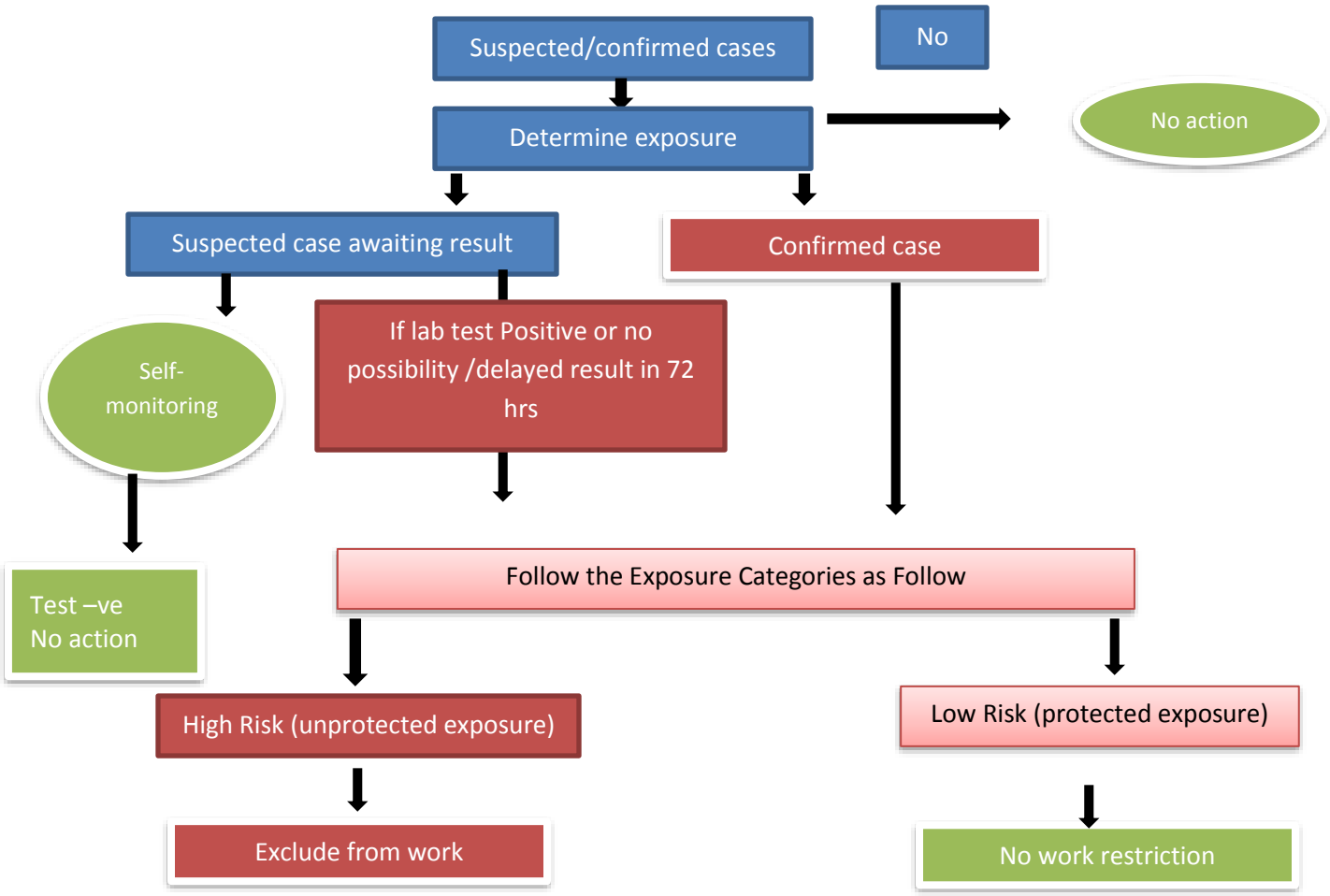
This interim guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to COVID-19. Because of their often extensive and close contact with vulnerable individuals in healthcare settings, a conservative approach to HCP monitoring and restriction from work was taken to quickly identify early symptoms and prevent transmission from potentially contagious HCP to patients, HCP, and visitors.

The feasibility and utility of performing contact tracing of exposed HCP and application of work restrictions depends upon the degree of community transmission of SARS-CoV-2 and the resources available for contact tracing. For areas with:

- Minimal to no community transmission of SARS-CoV-2, sufficient resources for contact tracing, and no staffing shortages, risk assessment of exposed HCP and application of work restrictions may be feasible and effective.
- Moderate to substantial community transmission of SARS-CoV-2, insufficient resources for contact tracing, or staffing shortages, risk assessment of exposed HCP and application of work restrictions may not be possible.

HCP who properly adhere to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

Risk Assessment Algorithm



Determining Exposure

HCW activities performed on suspected/confirmed COVID-19 patient in health care facility	
A. Did you provide direct care to a suspected/confirmed COVID-19 patient within 2 meter for prolonged time (15 min)?	□ Yes □ No □ Unknown
B. Did you have face-to-face contact (within 2 meter) with a suspected/confirmed COVID-19 patient in a health care facility for prolonged time (15 min)?	□ Yes □ No □ Unknown
C. Were you present when any aerosol-generating procedures were performed on the suspected/confirmed patient any time? See below for examples	□ Yes □ No □ Unknown
If yes, type of procedures	□ Tracheal intubation □ Nebulizer treatment □ Open airway suctioning □ Collection of sputum □ Tracheotomy □ Bronchoscopy □ Cardiopulmonary resuscitation (CPR) □ Other (specify):
D. Did you have unprotected direct contact with the infectious secretion/excretion of the suspected/confirmed COVID-19 patients and not hand washing immediately? E.g. touched soled handkerchief with bare hand	□ Yes □ No □ Unknown

If the health worker responds 'Yes' to any of the Questions A – D the health worker should be considered as being exposed to COVID-19 virus.
Note: Direct care refers to interventions that are carried out by having personal contact with patients. For example, Patient examination, cleaning an incision, administering an injection, ambulating with a patient, and completing patient teaching at the bedside.

Exposure Category

Exposure	PPE used	Work Restrictions for Asymptomatic HCP
HCP who had prolonged close contact with confirmed COVID cases as per above criteria	• HCP not wearing a respirator or facemask • HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask • 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 (institution/ home quarantine) if no testing is done • If testing is done on 7 days of last exposure to positive patient and the result is negative, he/she could return to work after 4 days' break • 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 for medical evaluation and testing.
HCP other than those with exposure risk described above		• 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 - not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19 at the beginning of their shift. • Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact for medical evaluation and testing.

HCP=healthcare personnel; PPE=personal protective equipment

Contingency capacity strategies to mitigate staff shortage for healthcare facilities include:

Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities.

- Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation and training to work in these areas that are new to them.
- Attempt to address social factors that might prevent HCP from reporting to work such as transportation or housing if HCP live with vulnerable individuals.
- Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
- Request that HCP postpone elective time off from work.

Crisis Capacity Strategies to Mitigate Staffing Shortages

Allow asymptomatic HCP who have had an unprotected exposure to SARS-CoV-2 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 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

    - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- 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.
- 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

If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are well enough to work but have not met all Return to Work Criteria to work. If HCP are allowed to work before meeting all criteria, they should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:

1. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
2. Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
3. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
4. As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients *without* suspected or confirmed COVID-19.

Return to work criteria

Symptomatic HCP with suspected or confirmed COVID-19 (Either strategy is acceptable depending on local circumstances):

- *Symptom-based strategy*. Exclude from work until:
    - 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 14 days have passed *since symptoms first appeared*

- *Test-based strategy.* Exclude from work until:
    - Resolution of fever without the use of fever-reducing medications **and**
    - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
    - Negative results of COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens)[1]. e.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

- *Time-based strategy.* Exclude from work until:
    - 14 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 14 days after their first positive test.

- *Test-based strategy*. Exclude from work until:

- Negative results of COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

Source: CDC/WHO

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

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

https://apps.who.int/iris/bitstream/handle/10665/331340/WHO-2019-nCov-HCW_risk_assessment-2020.1-eng.pdf