Coronavirus 2019 (COVID-19): Guidance for Healthcare Personnel Monitoring, Restriction, and Return to Work

This guidance is for employers of healthcare personnel (HCP) and includes best practice recommendations related to masking, eye protection, and HCP exposure, monitoring, and work restrictions for Coronavirus 2019 (COVID-19). **Except for current mandates in effect under a Mayor's Order or other existing local or federal regulation, any definitive action statements made in this guidance (e.g., "must") are considered essential best practice recommendations to mitigate the spread of COVID-19.** HCP include all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials. This guidance applies to all healthcare settings.

Healthcare facilities must have internal policies that address HCP monitoring, restriction and return to work in the context of COVID-19. Recommendations regarding HCP work restriction may not anticipate every potential scenario and will change as the local response progresses. This document will be updated as more information becomes available and as response needs change. For additional information, see coronavirus.dc.gov.

Key points to reinforce with HCP:

- Follow the facility policy for sick employees.
- Remain vigilant for symptoms of illness consistent with COVID-19.
- HCP who develop symptoms must stay home. If they develop symptoms at work, they must keep their mask on, isolate, notify their supervisor, and leave the facility.
- HCP must wear source control and eye protection in accordance with guidance for ***Required Personal Protective Equipment (PPE) for Healthcare Facilities*** at coronavirus.dc.gov/healthguidance.
    - HCP who are returning to work before a full 10 days of isolation, must wear a well-fitting mask for 10 days even if not required in the standard PPE guidance.

Monitoring signs and symptoms

Healthcare facilities must implement the following processes:

- Continuously educate HCP to remain vigilant for symptoms of illness consistent with COVID-19, such as fever (measured temperature ≥100 degrees Fahrenheit or subjective fever), chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.
- Facilities undergoing COVID-19 outbreaks should consider screening HCP at the start, middle, and end of each shift. If they are ill, have them keep their mask on and leave the workplace.

Key points for facilities experiencing staffing shortages

- DC Health has outlined two additional capacity strategies beyond conventional capacity to assist facilities in maintaining safe staffing levels.
- **IMPORTANT:** Capacity strategies must be implemented **in sequence** (i.e., implementing contingency strategies before using crisis strategies).
- Facilities are expected to use conventional capacity strategies when they are not experiencing significant staffing shortages.
    - **Facilities licensed and regulated by DC Health must obtain approval** to move outside of conventional capacity strategies prior to implementation. In collaboration with DC Health, they must:
        - Provide DC Health with reasonable justification as to why an alternative

capacity strategy is being requested.
    - **Email coronavirus.hai@dc.gov as soon as the potential for staffing shortages are identified for discussion and approval to move into an alternative capacity strategy.**
        - Approvals to move outside of conventional capacity are valid for 30 days unless otherwise indicated by DC Health.
        - Facilities anticipating continued staffing shortages beyond 30 days must request an extension at least 5 days prior to expiration.
        - Facilities whose approval is not extended or do not have a request pending are expected to return to conventional capacity.
- All facilities must have adequate surge planning to minimize the need to transition outside of conventional capacity strategies. **Facilities operating outside of conventional capacity must:**
    - Inform patients and visitors that modified isolation protocols are in use.
    - Cancel all non-essential (i.e., elective) procedures and visits to allow for reassigning of staff to support other patient care activities as appropriate. Cases deemed urgent (including those where a delay may result in a higher acuity condition as documented in the medical record) or emergent may proceed normally as safe staffing levels allow.
    - **Not compel or otherwise coerce an employee to return to work, based on an alternative isolation strategy, before they feel well enough to do so.**
    - Transition back to conventional capacity strategies once significant staffing shortages begin to resolve.
- Testing will remain critical to getting HCP with COVID-19 back to work safely.

Choosing a COVID-19 test

- Either an antigen test or a nucleic acid amplification test (NAAT e.g., PCR) test may be used.
- Testing is not recommended to detect new infection for asymptomatic HCP who tested positive in the last 30 days.
- Use an antigen test if the HCP:
    - Is symptomatic and tested positive in the last 30 days.
    - Tested positive for COVID-19 within the last 31-90 days.
- **Unlike NAAT tests, antigen tests are less likely to result in persistent positive results due to viral RNA shedding.**

Defining HCP exposure

- Exposure in the context of this guidance is a HCP who had prolonged (≥15 minutes over a 24-hour period) close contact (within 6 feet) with a patient, visitor, or HCP with confirmed COVID-19 **AND:**
    - HCP was not wearing a respirator (or if wearing a facemask, the person infected with SARS-CoV-2 is not wearing a mask).
      OR
    - HCP was not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask.
      OR
    - HCP was not wearing all recommended PPE while present for an **aerosol-generating procedure (AGP).**
        - **Any duration** is considered prolonged if the exposure occurred during an aerosol-generating procedure where PPE was indicated.
- When determining the time period when a patient, visitor, or HCP with confirmed COVID-19

could have been infectious, see the following:

- **For persons with confirmed COVID-19 who developed symptoms**, the exposure window is 2 days before symptom onset through the time when the individual meets criteria for discontinuation of transmission-based precautions or home isolation.
- **For persons with confirmed COVID-19 who never developed symptoms**, the exposure window is the 2 days prior to the date of specimen collection for the first positive SARS-CoV-2 viral test and will continue through the time when the individual meets criteria for discontinuation of transmission-based precautions or home isolation.

Testing after exposure

- Following an exposure, the HCP:
  - Must wear well-fitting source control while inside the healthcare facility for 10 days after exposure, regardless of vaccination status.

  AND
  - Get tested with a series of 3 viral tests beginning immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative and, if negative, again 48 hours after the second negative. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
- Staff must still monitor themselves for symptoms of COVID-19 for 10 days from the date of their exposure. If symptoms consistent with COVID-19 develop, they should immediately begin isolation, seek medical attention, and get re-tested for COVID-19.

Work Restriction[1] after exposure

- Work restriction is no longer required for **most** asymptomatic HCP following an exposure, regardless of vaccination status.
- Work restriction should still be considered based on the risk profile of the HCP and the population they care for, the presence of ongoing COVID-19 transmission within the facility, and the ability for HCP to follow recommendations after exposure for source control and testing.
- If work restriction is used:
  - HCP may return to work after day 7 following exposure (count the day of exposure as day 0) if no symptoms develop **AND** the series of 3 viral tests, as described above, are negative. A mask must still be worn through day 10.
  - If viral testing is not performed, and no symptoms develop, HCP may return to work after day 10 following exposure (count the day of exposure as day 0).
  - If symptoms of COVID-19 develop, the HCP should immediately begin isolation, seek medical attention, and get re-tested for COVID-19.

Testing and diagnosis of people with COVID-19

When HCP are tested, please note the following:

- **If a symptomatic HCP has a positive test result:**
  - HCP must follow the symptom-based strategy criteria for clearance to return to work. As an *exception*, the test-based strategy may be used for severely immunocompromised persons (see *Getting HCP back to work after SARS-Cov-2 infection* section below).
- **If a symptomatic HCP has negative test results:**
  - HCP who are still symptomatic at the time of test result must continue to follow the

[1] For work restriction calculation purposes, the date of exposure is considered **Day 0**. The first full day after date of exposure is **Day 1.**

facility policy for sick employees (i.e., stay home when sick).
    - If a HCP has had COVID-19 ruled out and has an alternate diagnosis, then criteria for return to work should be based on that diagnosis.
- **If a symptomatic HCP refuses testing:**
    - HCP must follow the symptom-based strategy criteria for clearance to return to work. If an alternative diagnosis is made by an evaluating HCP, they must continue to follow the facility policy for sick employees (i.e., stay home when sick).
- **If a HCP has laboratory-confirmed COVID-19 but never had any symptoms** (i.e., asymptomatic):
    - HCP must follow the recommended time period for clearance to return to work (see *Getting HCP Back to work after SARS-CoV-2 infection* section below).
- If a HCP is undergoing testing for COVID-19 because they have symptoms, **the HCP must not report to work while the test is pending.**
- **If a HCP is undergoing routine surveillance testing for COVID-19,** the HCP can still report to work**.**

Getting HCP back to work after SARS-CoV-2 infection

The HCP return-to-work guidance has been updated based on the current knowledge of transmission risk consistent with the Centers for Disease Control and Prevention (CDC) guidelines, noting that detecting viral RNA via NAAT does not necessarily mean that infectious virus is present. HCP with confirmed SARS-CoV-2 infection, or who have developed symptoms of COVID-19 but were never tested for SARS-CoV-2, should be excluded from work until they meet the criteria from the applicable strategy outlined below.

Symptomatic HCP with or without a positive COVID-19 test:

- **DC Health recommends the symptom-based strategy** be used to discontinue transmission-based precautions for HCP with COVID-19 who had symptoms and are ***not*** moderately to severely immunocompromised[2].
- **DC Health recommends the time-based strategy** be used for HCP who have laboratory-confirmed COVID-19 but never had any symptoms (i.e., asymptomatic), and who are ***not*** moderately to severely immunocompromised.
- **A test-based strategy** should be used for HCP who are moderately to severely immunocompromised and may be considered for HCP with severe[3] or critical illness[4]**.** The test-based strategy **must** be in consultation with an infectious disease expert and **must** not be used to discontinue transmission-based precautions earlier than if a symptom-based strategy was used.
    - If the test-based strategy is used to discontinue transmission-based precautions, the specimen should be processed in a private laboratory (and not to the DC Department of Forensic Sciences Public Health Laboratory).

[2] **Moderate to severely immunocompromised may include conditions such as** chemotherapy for cancer, receipt of solid organ transplant with immunosuppressive therapy, receipt of a CAR-T cell therapy or hematopoietic cell transplant (HCT) within 2 years or taking immunosuppressive therapy, moderate to severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), advanced or untreated HIV infection (people with HIV and CD4 T lymphocyte count <200/mm^3, history of AIDS-defining illness without immune reconstitution, or clinical symptomatic HIV), active treatment with high-dose corticosteroids (i.e., prednisone ≥20mg/day for more than 14 days), alkylating agents, antimetabolites, and other biologic agents that are immunosuppressive or immunomodulatory. The degree of immunocompromise for the patient is determined by the treating provider and are tailored to each individual situation.

[3] **Severe illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for individuals with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%. Note: For children, hypoxia should be the primary criterion that defines severe illness, especially in younger children.

[4] **Critical illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Symptom-based strategy[5]:

- **HCP with <u>mild[6] to moderate[7] illness</u> who are not moderate to severely immunocompromised:**
  - **Conventional Capacity:**
    - Option 1:
      - 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 **<u>IMPROVED</u>**[8]
    - Option 2:
      - At least 7 days have passed since symptoms first appeared
        AND
      - A negative SARS-CoV-2 antigen test (preferred) or NAAT is obtained within 48 hours prior to return to work
        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 **<u>MOSTLY RESOLVED</u>**

  - **Contingency Capacity:**
    - At least 5 days have passed since symptoms first appeared **<u>AND</u>**
    - 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 **<u>IMPROVED</u>**
    - It is strongly recommended to obtain a negative antigen test (preferred) or NAAT within 48 hours prior to return to work. Testing may be waived if testing capacity is severely limited.
  - **Crisis Capacity:**
    - At least 24 hours have passed since last fever without the use of fever-reducing medications
      AND
    - Symptoms (e.g., cough, shortness of breath) are **<u>IMPROVING</u>**

- **HCP with <u>severe or critical illness</u> or who are not moderate to severely immunocompromised:**
  - At least 10 days and up to 20 days have passed since symptoms first appeared
    AND

[5] For work restriction/**isolation** calculation purposes the date symptoms first started is considered **Day 0**. The first full day after symptom onset is **Day 1.**

[6] **Mild illness:** Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

[7] **Moderate illness:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

[8] Symptoms of altered taste and smell may continue for weeks to months after recovery from COVID-19 and these symptoms do not need to keep people in isolation.

- At least 24 hours have passed since last fever without the use of fever-reducing medications
  AND
- Symptoms (e.g., cough, shortness of breath) are **IMPROVING** (It is not required that symptoms be fully resolved.)
- Strongly consider consultation with infectious disease experts.

Test-based strategy[9]:

- **For HCP who are moderately to severely immunocompromised:**
  - At least 10 days and up to 20 days have passed since symptoms first appeared
    AND
  - Resolution of fever without the use of fever-reducing medications
    AND
  - Symptoms (e.g., cough, shortness of breath) have improved
    AND
  - Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using a SARS-CoV-2 antigen test or NAAT (nucleic acid amplification test)

Asymptomatic HCP with a positive COVID-19 test

If a HCP has laboratory-confirmed COVID-19 but never had any symptoms (i.e., asymptomatic), clearance to return to work must be based off the recommended time period outlined below. The recommended time period is based upon whether or not a HCP is severely immunocompromised.

Time-based strategy[10]:

- **HCP who are not moderate to severely immunocompromised and were asymptomatic throughout their infection:**
  - **Conventional Capacity:**
    - Option 1:
      - At least 10 days have passed since the date of the specimen collection of their first positive SARS-CoV-2 viral test.
    - Option 2:
      - At least 7 days have passed since the date of the specimen collection of their first positive SARS-CoV-2 viral test
        AND
      - A negative antigen test (preferred) or NAAT is obtained within 48 hours prior to return to work.
  - **Contingency Capacity:**
    - At least 5 days have passed since the date of the specimen collection of their first positive SARS-CoV-2 viral test
    - It is strongly recommended to obtain a negative antigen test (preferred) or NAAT within 48 hours prior to return to work. As a last resort, testing may be waived if testing capacity is severely limited.
  - **Crisis Capacity**
    - HCP may continue to work provided they remain asymptomatic.
      - This should only be done as a last resort.

[9] Test-based strategy may also be considered for HCP with severe to critical illness.

[10] For work restriction/**isolation** calculation purposes the date the positive specimen was collected is **Day 0**. The first full day after the positive specimen was collected is **Day 1.**

Test-based strategy:

- **HCP who are moderately to severely immunocompromised:**
  - At least 10 days and up to 20 days have passed since the date of the specimen collection of their first positive test for SARS-CoV-2 RNA.
    AND
  - Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using a SARS-CoV-2 antigen test or NAAT (nucleic acid amplification test)
  - Strongly consider consultation with infectious disease experts.

Return to work practices and work restrictions

- After returning to work, HCP must:
  - Continue wear a mask and eye protection while inside the healthcare facility as indicated in DC Health PPE Guidance. A facemask for source control does not replace the need to wear a respirator when indicated.
  - Adhere to hand hygiene, respiratory hygiene, and cough etiquette.
  - Must report new, recurring (e.g., rebound), or worsening symptoms to their established point of contact (such as occupational health) for immediate evaluation.
- HCP returning to work early as compared to conventional capacity:
  - Must always wear a respirator or well-fitting mask, even when in non-patient care areas (such as breakrooms).
  - Should eat meals in a designated area away from other people.
  - Should be restricted from contact with unvaccinated people and people not up to date on their COVID-19 vaccine, if possible, and those who are moderate to severely immunocompromised (regardless of vaccination status).

The guidelines above will continue to be updated as the outbreak evolves. Please visit coronavirus.dc.gov/healthguidance regularly for the most current information.