

**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 universal 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](https://coronavirus.dc.gov).

**Key points to reinforce with your 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 face mask or cloth face covering on, isolate, notify their supervisor, and leave the facility.
- HCP must be screened at the beginning of their shift for fever and symptoms of COVID-19.
- All HCP must wear a respirator or face mask (medical, surgical, or procedural) for source control while inside the HCF or any alternative setting where patient care services are provided, with the exception of temporary removal of masks for eating and drinking or for changing into a new mask.
- Staff must wear eye protection in accordance with guidance for **Required Personal Protective Equipment (PPE) for Healthcare Facilities** at [coronavirus.dc.gov/healthguidance](https://coronavirus.dc.gov/healthguidance).

**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  $\geq 100$  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.
- Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19; 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 cloth face covering or face mask on and leave the workplace.
  - Screening does not have to occur on-site for staff, and may be performed via an app or other electronic format.
  - Detailed *Guidance for Screening in a Healthcare Setting* can be found at [coronavirus.dc.gov/healthguidance](https://coronavirus.dc.gov/healthguidance)

### Key points for facilities experiencing staffing shortages

- The increasing number of COVID-19 cases due to the Omicron variant is expected to cause additional strain to healthcare facilities nationwide from staff absences.
- 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 not experiencing significant staffing shortages.
  - The decision to move outside of conventional capacity strategies must be approved in collaboration with DC Health.
  - Facilities must email [coronavirus.hai@dc.gov](mailto:coronavirus.hai@dc.gov) as soon as the potential for staffing shortages are identified.
- Facilities must have adequate surge planning to minimize the need to transition outside of conventional capacity strategies. Facilities outside conventional capacity must:
  - Inform patients and visitors that modified quarantine and isolation protocols are in use.
  - Cancel all non-essential procedures and visits to allow for reassigning of staff to support other patient care activities as appropriate.

### Defining HCP exposure

- HCP exposed to a confirmed COVID-19 case in a healthcare setting are recommended to follow the work restrictions outline in subsequent sections of this guidance.
- HCP must follow work restrictions regardless of where the exposure occurred.
- **HCP who have previously tested positive for SARS-CoV-2 are no longer exempt from work restriction after exposure.**
- Boosted HCP<sup>1</sup> do not need to be restricted from work as long as they remain asymptomatic but may still require testing as indicated in the “After Exposure” section on page 4.
- Work restrictions for facilities experiencing staffing shortages are outlined in Table 2 (see “Key points” section on page 7 for additional requirements).

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<sup>1</sup> **Boosted HCP** are defined as those who have received all recommended doses of the COVID-19 vaccine **AND** have also received a booster dose.

**Table 1: HCP Exposure Definition and Work Restrictions during Conventional Capacity (no staffing shortages)**

Exposure	PPE Used (Not Applicable for Community Exposures)	Work restrictions for Boosted HCP	Work restrictions for Vaccinated (not Boosted) or Unvaccinated HCP, regardless of previous COVID-19 infection
<p>HCP who had prolonged (≥15 minutes) close (within 6 feet) contact with a patient, visitor, or HCP with confirmed COVID-19</p>	<ul style="list-style-type: none"> <li>HCP not wearing a respirator (or if wearing a facemask, the person infected with SARS-CoV-2 is not wearing a mask). <b>OR</b></li> <li>HCP not wearing eyeprotection if the person with COVID-19 was not wearing a cloth face covering or facemask <b>OR</b></li> </ul> <p>HCP not wearing all recommended PPE while performing an <b>aerosol-generating procedure*</b></p>	<ul style="list-style-type: none"> <li>No work restriction needed <b>UNLESS</b> directed by DC Health during an uncontrolled outbreak. <b>AND</b></li> <li>Test on day 2, and 5-7 as indicated in the “After Exposure” section of this guidance. <b>AND</b></li> <li>Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 <b>AND</b></li> <li>Any HCP who develops fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (such as occupational health) at the facility. HCP should have medical evaluation and testing performed.</li> </ul>	<ul style="list-style-type: none"> <li>Exclude from work for 10 days after last exposure <b>or</b> 7 days with a negative COVID-19 test as indicated in the “After Exposure” section of this guidance. <b>AND</b></li> <li>Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 <b>AND</b></li> <li>Any HCP who develops fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (such as occupational health) at the facility. HCP should have medical evaluation and testing performed.</li> </ul>

- **\*Note: Any duration** is considered prolonged if the exposure occurred during an aerosol-generating procedure
- 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.
- Work restrictions should still be considered for immunocompromised<sup>2</sup> HCP, regardless of vaccination status, after exposure to a confirmed COVID-19 case.

<sup>2</sup> **Severely immunocompromised may include conditions such as** chemotherapy for cancer, being within one year from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise. The degree of immunocompromise for the patient is determined by the treating provider and are tailored to each individual situation.

**Table 2: HCP Exposure Work Restrictions During Staffing Shortages**

Capacity	Modified Work restrictions for Boosted HCP	Modified Work restrictions for Vaccinated (not Boosted) or Unvaccinated HCP, regardless of previous COVID-19 infection
<b>Contingency</b>	<ul style="list-style-type: none"> <li>• No work restriction needed <b><u>UNLESS</u></b> directed by DC Health during an uncontrolled outbreak. <b><u>AND</u></b></li> <li>• Test on day 2, and on day 5-7 as indicated in the “After Exposure” section of this guidance. <b><u>AND</u></b></li> <li>• Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 <b><u>AND</u></b></li> <li>• Any HCP who develops fever or <u>symptoms consistent with COVID-19</u> should immediately contact their established point of contact (such as occupational health) at the facility. HCP should have medical evaluation and testing performed.</li> </ul>	<ul style="list-style-type: none"> <li>• No work restriction needed <b><u>UNLESS</u></b> directed by DC Health during an uncontrolled outbreak. <b><u>AND</u></b></li> <li>• <u>Test</u> on days 1, 2, 3, and 5-7 as indicated in the “After Exposure” section of this guidance. <b><u>AND</u></b></li> <li>• Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 <b><u>AND</u></b></li> <li>• Any HCP who develops fever or <u>symptoms consistent with COVID-19</u> should immediately contact their established point of contact (such as occupational health) at the facility. HCP should have medical evaluation and testing performed.</li> </ul>
<b>Crisis</b>	<ul style="list-style-type: none"> <li>• No work restriction needed <b><u>UNLESS</u></b> directed by DC Health during an uncontrolled outbreak. <b><u>AND</u></b></li> <li>• Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 <b><u>AND</u></b></li> <li>• Any HCP who develops fever or <u>symptoms consistent with COVID-19</u> should immediately contact their established point of contact (such as occupational health) at the facility. HCP should have medical evaluation and testing performed.</li> </ul>	<ul style="list-style-type: none"> <li>• No work restriction needed <b><u>UNLESS</u></b> directed by DC Health during an uncontrolled outbreak. <b><u>AND</u></b></li> <li>• <u>Test</u> on days 1, 2, 3, and 5-7 as indicated in the “After Exposure” section of this guidance. <b><u>AND</u></b></li> <li>• Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 <b><u>AND</u></b></li> <li>• Any HCP who develops fever or <u>symptoms consistent with COVID-19</u> should immediately contact their established point of contact (such as occupational health) at the facility. HCP should have medical evaluation and testing performed.</li> </ul>

## Testing after exposure

### Conventional Capacity

- In addition to any work restrictions outlined in Table 1:
  - **Boosted HCP** with exposure to a confirmed COVID-19 case should get a COVID-19 test immediately<sup>3</sup> and (if the test is negative) get another test 5 to 7 days after their last exposure date. Testing is recommended regardless of prior COVID-19 infection.
  - **Vaccinated (not Boosted) or Unvaccinated HCP (regardless of previous COVID-19 infection)** with exposure to a confirmed COVID-19 case that wish to return to work after 7 days should get tested within 48 hours prior to return.

### Contingency Capacity:

- In addition to any work restrictions outlined in Table 2:
  - **Boosted HCP** with exposure to a confirmed COVID-19 case should get a COVID-19 test immediately and (if the test is negative) get another test 5 to 7 days after their last exposure date. Testing is recommended regardless of prior COVID-19 infection, but may be waived if testing capacity is limited.
  - **Vaccinated (not Boosted) or Unvaccinated HCP (regardless of previous COVID-19 infection)** with exposure to a confirmed COVID-19 case should get tested on days 1, 2, 3, and 5-7 after their last exposure date.

### Crisis Capacity:

- In addition to any work restrictions outlined in Table 2:
  - Testing is not needed for **boosted HCP** with exposure to a confirmed COVID-19 case.
  - **Vaccinated (not Boosted) or Unvaccinated HCP (regardless of previous COVID-19 infection)** with exposure to a confirmed COVID-19 case should get tested on days 1, 2, 3, and 5-7 after their last exposure date.

### Under all capacities:

- Staff must still monitor themselves for symptoms of COVID-19 for 14 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.
- For HCP return to work testing:
  - Either NAAT or antigen testing may be used.
  - Antigen tests are preferred for HCP who become symptomatic or for asymptomatic HCP who have previously recovered from a COVID-19 infection within the previous 90 days.

## 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 Back to Work' section below).

<sup>3</sup> CDC defines "immediately" as no sooner than 24 hours after the exposure occurred.

- **If a symptomatic HCP has negative test results:**
  - HCP who are still symptomatic at the time of test result must continue to follow the facility policy for sick employees (i.e., stay home when sick).
- **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, 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 recommend time period for clearance to return to work (see '[Getting Back to Work](#)' section below).
- **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 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 on quarantine and** has a negative COVID-19 test result during their quarantine period, the HCP must still complete their full quarantine period.
- **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 is being 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 PCR 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:**

Criteria for symptom-based strategy varies depending on the HCP's severity of illness and if the HCP is severely immunocompromised. **The test-based strategy is not recommended.** As an exception, a test-based strategy may be considered for some HCP (e.g., those who are severely immunocompromised or with critical illness<sup>4</sup>) if concerns exist for the patient being infectious for more than 20 days. **The decision to use 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 sent to a commercial laboratory (and not to the DC Department of Forensic Sciences Public Health Laboratory).

### ***Symptom-based strategy:***

- **HCP with mild<sup>5</sup> to moderate<sup>6</sup> illness who are not severely immunocompromised:**

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

<sup>5</sup> **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.

<sup>6</sup> **Moderate illness:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO<sub>2</sub>) ≥94% on room air at sea level.

- 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 **improved**
- **HCP with severe<sup>7</sup> to critical illness or who are severely immunocompromised:**
  - At least 10 days and up to 20 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) are **improving** (It is not required that symptoms be fully resolved.)
  - Strongly consider consultation with infectious disease experts.

**Test-based strategy:**

- 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  $\geq 24$  hours apart (total of two negative specimens) tested using an FDA-authorized laboratory-based NAAT (nucleic acid amplification test) to detect SARS-CoV-2 RNA.

**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:**

- **HCP who are not 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 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 **AND**

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<sup>7</sup>**Severe illness:** Individuals who have respiratory frequency  $>30$  breaths per minute, SpO<sub>2</sub>  $<94\%$  on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of  $>3\%$ ), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO<sub>2</sub>/FiO<sub>2</sub>)  $<300$  mmHg, or lung infiltrates  $>50\%$ . Note: For pediatric patients, hypoxia should be the primary criterion that defines severe illness, especially in younger children.

- A negative antigen test or NAAT is obtained within 48 hours prior to return to work.
  - **Crisis Capacity**
    - HCP may continue to work provided they remain asymptomatic.
      - This should only be done as a last resort.
- **For severely immunocompromised HCP who were asymptomatic throughout their infection:**
  - At least 10 days and up to 20 days have passed since the date of the specimen collection of their first positive SARS-CoV-2 viral test.

**Test-based strategy:**

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

**Return to work practices and work restrictions**

- After returning to work, HCP must:
  - Continue wear a mask while inside the healthcare facility. A facemask for source control does not replace the need to wear a respirator when indicated.
  - Continue to wear eye protection when indicated.
  - Adhere to hand hygiene, respiratory hygiene, and cough etiquette.
  - Must report new, recurring, 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, 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](https://coronavirus.dc.gov/healthguidance) regularly for the most current information.