

**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.

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 be screened at the beginning of their shift for fever and symptoms of COVID-19.
- 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 by the guidance listed above.

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.
- 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 mask on and leave the workplace.
 - Screening does not have to occur on-site for HCP, 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

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 outside conventional capacity must:**
 - Inform patients and visitors that modified quarantine and 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 back to work safely.
 - Either NAAT (nucleic acid amplification test) or antigen testing may be used.
 - Antigen testing is preferred when testing HCP that are:
 - symptomatic
OR
 - asymptomatic + a prior COVID-19 infection within the previous 90 days.
 - **Unlike NAAT tests, antigen tests are less likely to result in persistent positive results due to viral RNA shedding.**

Defining HCP exposure

- HCP exposed to a confirmed COVID-19 case in a healthcare setting are recommended to follow the work restrictions outlined 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 do not need to be restricted from work or tested for 90 days after their previous positive test or acute illness as long as they have fully recovered and remain asymptomatic.**
- HCP who are up to date on their COVID-19 vaccine, do not need to be restricted from work after exposure to a confirmed COVID-19 case as long as they remain asymptomatic.
 - A person is considered up to date with their COVID-19 vaccine after they have received all recommended doses of the vaccine, including all recommended booster doses. This includes HCP who:
 - Are fully vaccinated and boosted with all recommended doses when eligible;

- or
 - Are fully vaccinated and boosted but not yet eligible to receive the next booster dose; or
 - Are fully vaccinated after completing a primary vaccination series but not yet eligible to receive a booster dose.
- Testing may still be required as indicated in the “After Exposure” section on page 5.
- **For detailed information about staying up to date on your COVID-19 vaccine, see cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.**
- Work restrictions for facilities experiencing staffing shortages are outlined in Table 2 on page 4.

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

Exposure	PPE Used (Not Applicable for Community Exposures)	Work restrictions for HCP who are <u>up to date</u> ² on their COVID-19 vaccine or have recovered from COVID-19 infection within the last 90 days.	Work restrictions for HCP who are unvaccinated or <u>not up to date</u> ² on their COVID-19 vaccine.
HCP who had prolonged (≥15 minutes) close (within 6 feet) contact with a patient, visitor, or HCP with confirmed COVID-19	<ul style="list-style-type: none"> ● HCP not wearing a respirator (or if wearing a facemask, the person infected with SARS-CoV-2 is not wearing a mask). OR ● HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask OR ● HCP not wearing all recommended PPE while performing an aerosol-generating procedure* 	<ul style="list-style-type: none"> ● No work restriction needed UNLESS directed by DC Health during an uncontrolled outbreak. AND ● Test on day 2, and 5-7 as indicated in the “After Exposure” section of this guidance. AND ● Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 AND ● 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. 	<ul style="list-style-type: none"> ● Exclude from work for 10 days after last exposure or 7 days with a negative COVID-19 test as indicated in the “After Exposure” section of this guidance. AND ● Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 AND ● 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.

- ***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.

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

² See “Defining HCP exposure” section on page 2 for “**up to date**” definition.

- **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 immunocompromised³ HCP, regardless of vaccination status, after exposure to a confirmed COVID-19 case.

Table 2: HCP Exposure Work Restrictions During Staffing Shortages³

Capacity	Work restrictions for HCP who are <u>up to date</u> ² on their COVID-19 vaccine or have recovered from COVID-19 infection within the last 90 days.	Work restrictions for HCP who are unvaccinated or <u>not up to date</u> ² on their COVID-19 vaccine.
Contingency	<ul style="list-style-type: none"> ● No work restriction needed UNLESS directed by DC Health during an uncontrolled outbreak. AND ● Testing on day 2, and on day 5-7 is strongly recommended as indicated in the “After Exposure” section of this guidance. AND ● Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 AND ● 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. 	<ul style="list-style-type: none"> ● No work restriction needed UNLESS directed by DC Health during an uncontrolled outbreak. AND ● <u>Test</u> on days 1, 3, and 5-7 as indicated in the “After Exposure” section of this guidance. AND ● Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 AND ● 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.
Crisis	<ul style="list-style-type: none"> ● No work restriction needed UNLESS directed by DC Health during an uncontrolled outbreak. AND ● Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 AND ● 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. 	<ul style="list-style-type: none"> ● No work restriction needed UNLESS directed by DC Health during an uncontrolled outbreak. AND ● <u>Test</u> on days 1, 3, and 5-7 as indicated in the “After Exposure” section of this guidance. AND ● Advise HCP to monitor themselves for fever and symptoms consistent with COVID-19 AND ● 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.

³ **Immunocompromised** includes, but is not limited to: people on chemotherapy, people with blood cancers like leukemia, people who have had an organ transplant or stem cell transplant, and people on dialysis.

Testing after exposure

- **Reminder:** HCP who have previously tested positive for SARS-CoV-2 do not need to be tested for 90 days after their previous positive test or acute illness as long as they have fully recovered and remain asymptomatic.

Conventional Capacity

- In addition to any work restrictions outlined in Table 1:
 - **HCP who are up to date on their COVID-19 vaccine²** with exposure to a confirmed COVID-19 case should get a COVID-19 test immediately⁴ and (if the test is negative) get another test 5 to 7 days after their last exposure date.
 - **HCP who are unvaccinated or not up to date on their COVID-19 vaccine** 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:
 - **HCP who are up to date on their COVID-19 vaccine²** with exposure to a confirmed COVID-19 case are strongly recommended to 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 may be waived if testing capacity is severely limited.
 - **HCP who are unvaccinated or not up to date on their COVID-19 vaccine** with exposure to a confirmed COVID-19 case should get tested on days 1, 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 **HCP who are up to date on their COVID-19 vaccine²** with exposure to a confirmed COVID-19 case.
 - **HCP who are unvaccinated or not up to date on their COVID-19 vaccine** with exposure to a confirmed COVID-19 case should get tested on days 1, 3, and 5-7 after their last exposure date. Testing may be waived if testing capacity is severely limited.

Under all capacities:

- 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.

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).
- **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).

⁴ CDC defines "immediately" as no sooner than 24 hours after the exposure occurred.

- **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 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 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 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:

- **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 immunocompromised⁵.
- **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 severe⁶ or critical illness⁷. 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

⁵ **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/mm³, 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.

⁶ **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.

⁷ **Critical illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Forensic Sciences Public Health Laboratory).

Symptom-based strategy⁸:

- **HCP with mild⁹ to moderate¹⁰ illness 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 **IMPROVED**¹¹
 - 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 **MOSTLY RESOLVED**
 - **Contingency Capacity:**
 - At least 5 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**
 - 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 **IMPROVING**
- **HCP with severe or critical illness or who are not moderate to severely immunocompromised:**
 - At least 10 days and up to 20 days have passed since symptoms first appeared

⁸ 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**.

⁹ **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.

¹⁰ **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.

¹¹ 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.

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 strategy¹²:

- **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 strategy¹³:

- **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.

¹² Test-based strategy may also be considered for HCP with severe to critical illness.

¹³ 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 while inside the healthcare facility as indicated in DC Health Guidance. A facemask for source control does not replace the need to wear a respirator when indicated.
 - Continue to wear eye protection as indicated in DC Health Guidance.
 - 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 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.