



## Coronavirus Disease 2019 (COVID-19)

# Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19

### Update:

*The interim guidance was updated on May 29, 2020. Updates include:*

- **Any duration** of exposure should be considered prolonged if the exposure occurred during performance an aerosol-generating procedure.
- The time period that should be used for contact tracing after exposure to asymptomatic individuals who test positive for SARS-CoV-2 was shortened.
  - The time period was changed **from 10 days** before obtaining the specimen that tested positive for COVID-19 **to 2 days** to accommodate pragmatic and operational considerations for the implementation of case investigation and contact tracing programs.
  - Recent data suggest that asymptomatic persons may have a lower viral burden at diagnosis than symptomatic persons. Thus, the longer contact elicitation window (10 days) may have limited impact in identifying new COVID-19 cases.
  - The recommendation for the shorter contact elicitation window (2 days) will help focus case investigation and contact tracing resources toward activities most likely to interrupt ongoing transmission.
  - This time period is also now in alignment with recommendations from the World Health Organization, European CDC, and Public Health Canada.

*The interim guidance was updated on May 23, 2020 to clarify the definition of exposure for HCP not wearing eye protection.*

*This interim guidance was updated on May 19, 2020. Updates include:*

- Simplifying exposures warranting work restrictions for healthcare personnel.
- Changing the definition of prolonged exposure to more closely align with the definition used for community exposures and contact tracing (15 minutes or longer).
- Providing flexibility in approaches for healthcare facilities depending on the degree of community transmission and availability of resources to perform contact tracing.

## Purpose

This interim guidance is intended to assist with assessment of risk and application of work restrictions for asymptomatic healthcare personnel (HCP) with potential exposure to patients, visitors, or other HCP with confirmed COVID-19. Separate guidance is available for [travel-](#) and [community-related](#) exposures. The community-related exposure guidance can be used to inform risk assessment for patients and visitors exposed to SARS-CoV-2 in a healthcare setting. **CDC has also released guidance about [return to work criteria for HCP with COVID-19](#) and [strategies for mitigating HCP staffing shortages](#).**

Because of their often extensive and close contact with vulnerable individuals in healthcare settings, a conservative approach to HCP monitoring and applying work restrictions is recommended to prevent transmission from potentially contagious HCP to patients, other HCP, and visitors. Occupational health programs should have a low threshold for evaluating symptoms and testing HCP.

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.

This guidance is based on currently available data about COVID-19. Recommendations regarding which HCP are restricted from work might not anticipate every potential scenario and will change if indicated by new information. Occupational health programs should use clinical judgement as well as the principles outlined in this guidance to assign risk and determine the need for work restrictions. This approach might be refined and updated, including defining the role of testing exposed HCP as more information becomes available and as response needs change in the United States.

## Evolution of Currently Recommended HCP Assessment Guidance

CDC's recommendations for the assessment of and response to HCP exposures to SARS-CoV-2-infected patients have evolved as the incidence of COVID-19 in the United States has changed. Before recognized widespread transmission in the United States, CDC recommended an aggressive approach to identifying exposed HCP and included recommendations for restricting some HCP from work who had higher risk exposures. As community spread of COVID-19 became apparent in many areas and as transmission from asymptomatic individuals was recognized, this approach became impractical and diverted resources away from other critical infection prevention and control functions. In response, CDC advised facilities to consider forgoing formal contact tracing and work restrictions for HCP with exposures in favor of universally applied symptom screening and source control strategies.

This updated guidance describes a process for **resumption of contact tracing and application of work restrictions** that can be considered in areas where spread in the community has decreased and when capacity exists to perform these activities without compromising other critical infection prevention and control functions. It has been simplified to focus on exposures that are believed to result in higher risk for HCP (e.g., prolonged exposure to patients with COVID-19 when HCP's eyes, nose, or mouth are not covered). Other exposures not included as higher risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth. The specific factors associated with these exposures should be evaluated on a case by case basis; interventions, including restriction from work, can be applied if the risk for transmission is deemed substantial.

The definition of “**prolonged**” was extended to refer to a time period of 15 or more minutes, which aligns with the time period used in the guidance for [community exposures](#) and [contact tracing](#) . However, **any duration** should be considered prolonged if the exposure occurs during performance of an [aerosol-generating procedure](#).<sup>1</sup>

## Guidance for Asymptomatic HCP Who Were Exposed to Individuals with Confirmed COVID-19

Higher-risk exposures generally involve exposure of HCP’s eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure.


*This guidance applies to HCP with potential exposure in a healthcare setting to patients, visitors, or other HCP with confirmed COVID-19. Exposures can also occur from a suspected case of COVID-19 or from a person under investigation (PUI) when testing has not yet occurred or if results are pending. Work restrictions described in this guidance might be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. Therefore, a record of HCP exposed to PUIs should be maintained. If test results will be delayed more than 72 hours or the patient is positive for COVID-19, then the work restrictions described in this document should be applied.*

Exposure	Personal Protective Equipment Used	Work Restrictions
HCP who had prolonged <sup>1</sup> close contact <sup>2</sup> with a patient, visitor, or HCP with confirmed COVID-19 <sup>3</sup>	<ul style="list-style-type: none"> <li>• HCP not wearing a respirator or facemask<sup>4</sup></li> <li>• HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask</li> <li>• HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Exclude from work for 14 days after last exposure<sup>5</sup></li> <li>• Advise HCP to monitor themselves for fever or <a href="#">symptoms consistent with COVID-19</a><sup>6</sup></li> <li>• Any HCP who develop fever or <a href="#">symptoms consistent with COVID-19</a><sup>6</sup> should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.</li> </ul>
HCP other than those with exposure risk described above	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• No work restrictions</li> <li>• Follow all <a href="#">recommended infection prevention and control practices</a>, including wearing a facemask for source control while at work, monitoring themselves for fever or <a href="#">symptoms consistent with COVID-19</a><sup>6</sup> and not reporting to work when ill, and undergoing active screening for fever or <a href="#">symptoms consistent with COVID-19</a><sup>6</sup> at the beginning of their shift.</li> </ul>

- Any HCP who develop fever or [symptoms consistent with COVID-19<sup>6</sup>](#) should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.

HCP with [travel](#) or [community](#) exposures should inform their occupational health program for guidance on need for work restrictions.

HCP=healthcare personnel

1. Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, it is reasonable to consider an exposure of 15 minutes or more as prolonged. However, **any duration** should be considered prolonged if the exposure occurred during performance of an [aerosol generating procedure](#).
2. Data are limited for the definition of close contact. For this guidance it is defined as: a) being within 6 feet of a person with confirmed COVID-19 or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.
3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 could have been infectious:
  1. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets [criteria for discontinuation of Transmission-Based Precautions](#)
  2. For individuals with confirmed COVID-19 who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with COVID-19 may have been exposed could help inform the period when they were infectious.
    1. In general, individuals with COVID-19 should be considered potentially infectious beginning 2 days after their exposure until they meet [criteria for discontinuing Transmission-Based Precautions](#).
    2. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of [2 days](#)  prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.
4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into this risk assessment. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown.
5. If staffing shortages occur, it might not be possible to exclude exposed HCP from work. For additional information and considerations refer to [Strategies to Mitigating HCP Staffing Shortages](#).
6. Fever is either measured temperature  $\geq 100.0^{\circ}\text{F}$  or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such situations. Occupational health programs should have a low threshold for evaluating symptoms and testing HCP

# Definitions:

**Healthcare Personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.

## Other Resources

[Public Health Recommendations after Travel-Associated COVID-19 Exposure](#)

[Public Health Recommendations for Community-Related Exposure](#)

[Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 \(Interim Guidance\)](#)

[Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)

[Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease \(COVID-19\) in a Healthcare Setting.](#)

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