Information on COVID-19 Exposure

Did I have a close contact exposure?

Within the last 14 days, were you within approximately 6 feet *or* in the room *or* care area **for a period of 10 minutes or more** with a known COVID-19 case **while not wearing recommended personal protective equipment?** **OR**
Did you have **direct contact with infectious secretions** of a known COVID-19 case (being coughed on), or exposure during an aerosol-generating procedure **while not wearing recommended personal protective equipment?**

If you answered **"Yes"** to either of the above, you had a close contact exposure which puts you at **High Risk**

YES

NO

- Wash your hands for 20 seconds frequently
- Practice social distancing (*physically staying away from others as much as possible)*
- If you must go into shared spaces, remain at least six feet away from others
- Do not touch your face
- Wear a mask

Exposure	Personal Protective Equipment Used	Work Restrictions
HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed COVID-19[3]	• HCP not wearing a respirator or facemask[4] • 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[1]	• Exclude from work for 14 days after last exposure[5] • 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 their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
HCP other than those with exposure risk described above	• N/A	• 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[6] and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19[6] at the beginning of their shift. • Any HCP who develop fever or symptoms consistent with COVID-19[6] 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.		

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 a total 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.

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.*

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, **a**ny 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 the CDC guidance on Strategies to Mitigating HCP Staffing Shortages.
6. *For the purpose of this guidance, fever is defined as subjective fever (feeling feverish) or a measured temperature of 100.0°F (37.8°C) or higher. Note that fever may be intermittent or may not be present in some people, such as those who are elderly, immunocompromised, or taking certain fever-reducing medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDS]).

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.

Returning to Duty for EMS personnel with SARS-CoV-2 Infection

Symptom-based strategy for determining when HCP can return to work.

HCP = Health Care Provider which includes EMS professionals

*HCP with **mild to moderate illness** who are not severely immunocompromised:*

- 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

Note: HCP who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

*HCP with **severe to critical illness** or who are severely immunocompromised[1]:*

- At least 10 days and up to 20 days have passed *since symptoms first appeared*
- 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
- Consider consultation with infection control experts

Note: HCP who are **severely immunocompromised** but who were **asymptomatic** throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

As described in the CDC decision memo, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patient had replication-competent virus more than 20 days after onset of symptoms. The exact criteria that determine which HCP will shed replication-competent virus for longer periods are not known. Disease severity factors and the presence of immunocompromising conditions should be considered in determining the appropriate duration for specific HCP. For example, HCP with characteristics of severe illness may be most appropriately managed with at least 15 days before return to work.

Test-Based Strategy for Determining when HCP Can Return to Work.

In some instances, a test-based strategy could be considered to allow HCP to return to work earlier than if the symptom-based strategy were used. However, as described in the CDC decision memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCP (e.g., those who are severely immunocompromised[1]) in consultation with local infectious diseases experts if concerns exist for the HCP being infectious for more than 20 days.

The criteria for the test-based strategy are:

HCP who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**
- 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.

HCP who are not symptomatic:

- 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 should:

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. 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 equivalent or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed SARS-CoV-2 infection.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen.

Strategies to Mitigate Healthcare Personnel Staffing Shortages

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above. Refer to the *Strategies to Mitigate Healthcare Personnel Staffing Shortages* document for information.

Who to Contact if I Have Questions?

Who to call if COVID-19 infection is suspected?
Call ISDH Call Center (877) 826-0011 (open 24/7) or visit website at https://coronavirus.in.gov

Additional Resources
CDC has an online COVID-19 Self-Checker for those who think they have been exposed or are infected with the virus: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Anthem NurseLine: Call 800-337-4770 or visit the Anthem NurseLine online for a FREE symptom screening. Available to anyone with an Anthem health plan (this includes State of IN employees)

IF YOU HAVE SYMPTOMS OF COVID-19, YOU MUST STAY AT HOME.