COVID-19 Recommendations for Health Care Workers

12/8/2021


MDH is working to update this guidance.

Health care workers with exposure to COVID-19

Health care organizations should identify, manage, and monitor health care workers (HCW) who have experienced a higher-risk (unprotected) exposure to a patient, resident, coworker, or household/social contact with confirmed COVID-19. Most HCW who have had a higher-risk exposure are identified through occupational tracking of personal protective equipment (PPE) breaches; contact tracing and assessment of PPE worn while in contact with a COVID-19-positive patient, resident, or coworker; or reports of a community exposure to a COVID-19-positive person in a household or social setting. Household and social exposures are more likely to lead to HCW COVID-19 infection compared to occupational exposures, and should be considered an important factor when assessing higher-risk exposures.

HCW, regardless of vaccination status, who have had unprotected exposure to a person with confirmed COVID-19, but who remain asymptomatic, should be tested immediately upon identification of the case (but not earlier than two days after exposure) and five to seven days following the date of exposure, at a minimum. HCW with ongoing exposure to a positive household member should be tested every three to five days, with the final test occurring five to seven days after their last exposure (i.e., when their household member is no longer considered infectious). HCW should be tested if symptomatic at any time.

When an exposure is identified, the facility should perform the following actions.

- For lower-risk exposures, the facility should provide the Health Care Worker Monitoring for COVID-19 Low-risk Exposure (www.health.state.mn.us/diseases/coronavirus/hcp/lowrisk.pdf) fact sheet to HCW by email and explain self-monitoring of symptoms. If an employee having a lower-risk exposure develops symptoms consistent with COVID-19, they should be excluded from work and tested immediately.

- For all higher-risk exposures, the facility should provide the Health Care Worker Monitoring for COVID-19 High-risk Exposure (www.health.state.mn.us/diseases/coronavirus/hcp/highrisk.pdf) fact sheet to HCW, maintain awareness of HCW symptoms and health status, and assist in coordination of testing, if necessary. If an employee with a higher-risk exposure develops symptoms consistent with COVID-19, they should be excluded from work immediately.
If COVID-19 testing is necessary, facilities should assist in coordinating specimen collection, unless HCW choose to seek care elsewhere.

**Fully vaccinated health care workers**

Fully vaccinated HCW who remain asymptomatic do not need to quarantine from work or the community for the 14 days following their exposure. HCW are considered fully vaccinated two weeks after their final COVID-19 vaccine dose (two doses in a two-dose series or one dose in a one-dose series). HCW who return to work in the 14 days following their exposure must wear a medical-grade face mask for source control at all times.

Work restriction for 14 days may still be considered for:

- HCW who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which may impact the level of protection provided by the COVID-19 vaccine. Data is limited on which immunocompromising conditions may affect response to the COVID-19 vaccine or increase risk of vaccine breakthrough infections.
- HCW with ongoing household exposures, at the discretion of the health care facility and as staffing resources allow.

In rare situations, MDH may recommend quarantine of fully vaccinated HCW after exposure to a newly recognized variant of concern or variant of high consequence. CDC continues to evaluate the impact of vaccination and the emergence of novel SARS-CoV-2 variants on health care infection prevention and control recommendations.

**Unvaccinated health care workers**

- Unvaccinated health care workers who experience a higher-risk exposure to a person with COVID-19, either inside or outside of the health care facility, should be excluded from work for 14 days.
- HCW may consider temporarily moving into alternative accommodations, if available, to maintain distance from an ill household member and shorten the period of work exclusion. The quarantine period does not begin until the last date of exposure to the test-positive household member.

There are employment protections for a person who is staying away from work because of a health department recommendation. According to Minnesota Statutes, section 144.4196, Employee Protection (www.revisor.mn.gov/statutes/cite/144.4196), employers may not discharge, discipline, threaten, penalize, or otherwise discriminate in the work terms, conditions, or privileges of employment when an employee chooses to follow quarantine or isolation recommendations. While CDC guidance allows employers that have exhausted other staffing options to ask asymptomatic employees to work during quarantine, it is the employee’s right to make the choice to return or to remain in quarantine.

Unvaccinated HCW may return to community activities (i.e., non-work) based on the quarantine options outlined in the community quarantine guidance. Exposed HCW should continue to self-monitor for signs and symptoms of COVID-19 through day 14. If signs or symptoms develop at any time during the 14-day period, HCWs should seek testing and isolate at home.

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1 [Quarantine Guidance for COVID-19](www.health.state.mn.us/diseases/coronavirus/quarguide.pdf)
Travel recommendations for health care workers

Travel increases your chances of becoming infected and transmitting SARS-CoV-2. CDC and MDH recommend that unvaccinated people do not travel at this time. Delay travel and stay home to protect yourself and others from COVID-19.

CDC has outlined considerations for travel (e.g., transportation, accommodation, activities), and potential associated risk. Health care organizations should review CDC resources to establish expectations for HCW around travel, and the course of action (e.g., testing, 14-day quarantine) that will be taken for HCW who participate in nonessential travel.


For more recommendations and things to consider before, during, and after travel, visit:

- Protect Yourself & Others: COVID-19, Traveling (www.health.state.mn.us/diseases/coronavirus/prevention.html#travel)

Standards for bringing health care workers back to work after experiencing a higher-risk exposure

Health care facilities experiencing an acute staffing shortage should have a systemic crisis staffing plan in place with options that systematically address staff shortages. For example: bonuses; leadership assisting with direct patient care; 12- versus eight-hour shifts; hazard pay; and reducing non-time-sensitive procedures. Facilities should exhaust all alternative options before asking asymptomatic unvaccinated HCW who are in quarantine to return to work. If necessary, unvaccinated HCW in quarantine should be brought back to work, using the following standards. This information does not pertain to asymptomatic SARS-CoV-2-positive HCW, who should be excluded from the workplace until they meet return-to-work criteria for people with COVID-19.

- Minnesota Statutes, section 144.4196, Employee Protection (www.revisor.mn.gov/statutes/cite/144.4196) protects workers from retaliation or from being forced to work if they choose to stay home during their quarantine period.

- Different types of higher-risk exposures carry different risks of testing positive for COVID-19. Therefore, facilities should ask exposed HCW to return to work in the order listed below. All HCW from one group should be asked to return prior to bringing back HCW from the next group. Facilities should also take into account specialty-specific or unit-specific needs when asking HCW with higher-risk exposures to return.

1. Unvaccinated (or not fully vaccinated) HCW with occupational higher-risk exposure to a patient, resident, or coworker.
2. Unvaccinated (or not fully vaccinated) HCW with recent return from nonessential travel. If travel was by private car, consistent prevention measures were used, and HCW stayed only with household members, they may be brought back before HCW with known occupational exposure.
3. Unvaccinated (or not fully vaccinated) HCW with higher-risk exposure to a social contact.
4. Unvaccinated (or not fully vaccinated) HCW with higher-risk exposure to a household member; HCW with a household exposure should return only if able to isolate from the test-positive household member.

- Exposed HCW who return during quarantine should take on a role that does not have direct patient care duties (e.g., telemedicine, phone triage), when feasible.
If it remains necessary for HCW to provide direct patient care during the quarantine period, the HCW should:

- Avoid seeing high-risk patients (e.g., older adults, immunocompromised people, and those with comorbidities), if possible.
- Practice diligent hand hygiene and wear a medical-grade face mask at all times.
- Avoid sharing break room or lunchroom with coworkers.
- Monitor themselves closely for any symptoms associated with COVID-19 (e.g., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or loss of taste or smell), and measure body temperature daily before going to work.
- Remain at home and notify their supervisor if they develop respiratory symptoms OR if they have a measured body temperature higher than 100 degrees Fahrenheit.
- If at work when fever or respiratory symptoms develop, immediately notify their supervisor and go home.
- Notify their supervisor of other symptoms (e.g., fever higher than 100 degrees Fahrenheit, nausea, vomiting, diarrhea, abdominal pain, runny nose, fatigue), as medical evaluation may be recommended.
- HCW who have had a higher-risk exposure and return to work during quarantine should be proactively tested post-exposure. Specific testing protocols are dependent on the health care facility testing capacity and turnaround time. At a minimum, MDH recommends that exposed HCW who work during the 14-day quarantine period be tested immediately upon identification of the case (but not earlier than two days after exposure) and if negative, between days five and seven following the date of the higher-risk exposure.
- HCW should consider a self-assessment mid-shift for signs and symptoms of COVID-19 while working during quarantine.
- Facilities should increase audits for PPE, hand hygiene, and activity in break rooms and lunchrooms, and limit the number of HCW in break rooms to ensure social distancing. HCW working during a quarantine period should take breaks alone in the break room, if possible.

Facilities should maximize awareness of potential SARS-CoV-2 spread within the facility, following recommendations from MDH for assessment of clusters of people (patients, residents, HCW) who have symptoms or who have tested positive. Maintain a low threshold for investigating increases in staff calling in sick and for observing fatigue in using personal protective equipment in areas such as break rooms.

Management of staffing shortages

Health care facilities may continue to experience staffing shortages despite recalling asymptomatic HCW who experienced a higher-risk exposure but have not tested positive for COVID-19. Refer to the following guidance for additional staffing considerations.

- Clarification of Staffing Options for Congregate Care Facilities Experiencing Staff Shortages (www.health.state.mn.us/diseases/coronavirus/hcp/staffoptions.html)
Guidance for ill health care workers with confirmed or suspected COVID-19

As recommended above, HCW who become ill with respiratory symptoms OR fever (higher than 100 degrees Fahrenheit) should communicate with their supervisor and stay out of work. HCW with this clinical presentation are considered to have a suspected or confirmed (with laboratory testing) diagnosis of COVID-19. CDC has provided return to work criteria: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html). A symptom-based strategy is recommended and includes:

- HCW with mild to moderate illness who are not severely immunocompromised should stay away from work until:
  - At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); AND,
  - At least 10 days have passed since symptoms first appeared.
- HCW who are asymptomatic throughout their infection and are not severely immunocompromised should stay away from work until:
  - At least 10 days have passed since the date of their first positive test
- HCW with severe to critical illness or who are severely immunocompromised should stay away from work until:
  - At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); AND,
  - At least 20 days have passed since symptoms first appeared.
- HCW who are severely immunocompromised but remain asymptomatic throughout their infection should be excluded from work for 20 days following specimen collection.

If asymptomatic people subsequently develop symptoms after their positive test, their return to work should be guided by the recommendations for symptomatic COVID-19, above.

A test-based strategy is generally not recommended to determine when to allow HCW to return to work, but could be considered in specific situations (e.g., HCW who are moderately to severely immunocompromised) to allow HCW to return to work sooner than the symptom-based strategy.

HCW who present to work or screen positive with cold or flu symptoms should leave work immediately and be tested for COVID-19. If HCW do not get tested or test positive, follow the COVID-19 work exclusion and isolation guidance outlined above. If HCW test negative and they still experience symptoms, HCW should follow the guidance below:

- If persistent symptoms are consistent with an established chronic health condition, HCW may return to work after consultation with their manager and occupational health department. Evaluation of acute symptoms by a health care provider may also be indicated.
- If persistent symptoms are not consistent with a known chronic health condition, HCW should be evaluated by a health care provider.
  - If the health care provider provides an alternate diagnosis, criteria for return to work should be based on that diagnosis.
If the health care provider does NOT provide an alternate diagnosis and HCW do NOT have a known higher-risk exposure to a person with confirmed COVID-19, HCW should remain isolated and not return to work until at least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath).

If the health care provider does NOT provide an alternate diagnosis and HCW do have a known higher-risk exposure, HCW should obtain a second SARS-CoV-2 nucleic acid amplification (NAAT) test. HCW should remain isolated until the test results are known.

- If positive, follow the COVID-19 work exclusion and isolation guidance outlined above.
- If negative, HCW may return to work following the test-based strategy if at least 24 hours have passed since resolution of fever and symptoms are improving.

HCW who experience symptoms following vaccination for SARS-CoV-2:

- Systemic signs and symptoms, such as fever, fatigue, headache, chills, myalgia, and arthralgia, can occur following COVID-19 vaccination. Facilities should refer to CDC: Post-vaccination Considerations for Workplaces (www.cdc.gov/coronavirus/2019-ncov/community/workplaces-businesses/vaccination-considerations-for-workplaces.html) for guidance on evaluation and work exclusion for HCW who experience symptoms following vaccination.

Guidance for recovered health care workers who are exposed to COVID-19

HCW with past confirmed COVID-19 infection should return to work based on the symptom-based strategy recommended above. Within three months of COVID-19 symptoms starting or of a positive test for SARS-CoV-2, asymptomatic HCW with a higher-risk exposure to a confirmed COVID-19-positive person do not need to be quarantined or retested, but should self-monitor for symptoms consistent with COVID-19. If symptoms develop, exposed HCW should be assessed and potentially tested for SARS-CoV-2, if an alternate etiology is not identified. However, if HCW have a higher-risk exposure to a confirmed case three months or more after onset of their initial illness, HCW should follow quarantine and work exclusions outlined above.

MDH does not currently recommend using serological tests to determine whether previously infected HCW can continue to work after experiencing a new exposure to a person with COVID-19. There are currently insufficient data regarding immunological response and protective immunity after COVID-19 infection. Because the interval between resolution of illness and development of any protective immunity is also unknown, viral carriage and transmission to others during this period cannot be ruled out.

Guidance for communal activities among health care workers within a health care setting

Unvaccinated and fully vaccinated HCW should continue to wear a medical-grade face mask and eye protection while at work for source control, maintain appropriate physical distancing while interacting with coworkers, and follow the recommended transmission-based precautions while caring for patients or residents.

CDC has outlined considerations for health care facilities to allow HCW to gather without source control or physical distancing if all present are fully vaccinated and the facility is located in a county with low to moderate community transmission. MDH does not have specific recommendations on this topic. Medical and legal
leadership should develop health care facility-specific protocols and procedures, which may or may not include the relaxation of source control and distancing outlined by CDC for fully vaccinated HCW.


- **CDC COVID Data Tracker:** COVID-19 Integrated County View (https://covid.cdc.gov/covid-data-tracker/#county-view)

CDC considerations for allowing HCW to gather without source control or physical distancing include:

- Transmission level. The CDC recommends that these gatherings occur only in health care facilities located in counties with low to moderate community transmission, as defined by CDC.

- Vaccination status. If any unvaccinated HCW are present, all HCW should wear source control, and physically distance.

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Data collected by MDH supports an increased emphasis on limiting close interactions among coworkers, using universal masking for source control, and robust health monitoring.

- As of Oct. 18, 2021, health care workers in noncongregate care settings were more likely to test positive after a higher-risk exposure to a COVID-19 positive coworker compared to a patient (3.0% versus 1.6%, respectively) (unpublished data).

- For more details about the HCW monitoring program, refer to [SARS-CoV-2 Exposure and Infection Among Health Care Personnel — Minnesota, March 6–July 11, 2020](www.cdc.gov/mmwr/volumes/69/wr/mm6943a5.htm).

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**Best practices for health care workers**

- Stay home while ill. Do not report to work if you have any signs consistent with COVID-19 (measured or subjective fever) or symptoms (e.g., cough, shortness of breath, sore throat, muscle aches, headache, loss of taste or smell). If you develop fever or respiratory symptoms at work, isolate yourself immediately, leave work and report symptoms to your supervisor or occupational health services before departure.

- Health care workers who are fully vaccinated do not need to quarantine from work or community activities in the 14 days following a higher-risk exposure. Health care workers are fully vaccinated two weeks after their final COVID-19 vaccine dose (two doses in a two-dose series or one dose in a one-dose series). These health care workers should self-monitor for signs and symptoms of COVID-19 through day 14. If signs or symptoms develop at any time during the 14-day period, they should seek testing and isolate at home.

  - Refer to the [Fully vaccinated health care workers](#) section above for more detail.

- Health care workers who are not fully vaccinated should remain out of work for 14 days after a higher-risk exposure, unless asked to return to work because of a staffing shortage. Health care workers who are not fully vaccinated may return to community activities based on the quarantine options outlined in the community quarantine guidance\(^2\). Continue to self-monitor for signs and symptoms of COVID-19 through day 14. If signs or symptoms develop at any time during the 14-day period, seek testing and isolate at home.

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\(^2\) [Quarantine Guidance for COVID-19](www.health.state.mn.us/diseases/coronavirus/quarguide.pdf)
COVID-19 Recommendations for Healthcare Workers

- Health Advisory: Quarantine Duration for SARS-CoV-2 Contacts (www.health.state.mn.us/communities/ep/han/2020/dec7iq.pdf)

- Report recognized higher-risk exposures that occur in social or household settings in the community to supervisors, occupational health, or the appropriate entity in your facility.

- Adhere to strict hand hygiene at all times.

- Clean and disinfect high-contact personal items often (e.g., cell phone, computer keyboards, tablets, etc.).

- Medical-grade face masks or N95 respirators for source control should be used in all health care settings, including during non-patient encounters when social distancing is not possible, except when facility policies outline other recommendations for fully vaccinated health care workers (as described above). Ensure that all face masks are well fitted.


- Report to your supervisor or occupational health services any recognized coworker illness and PPE breaches when caring for a person with suspected or confirmed COVID-19.

Definitions

Using CDC’s COVID Data Tracker, COVID-19 Integrated County View (https://covid.cdc.gov/covid-data-tracker/#county-view): The tracker uses two different indicators (total new cases and test percent positivity) to determine the level of SARS-CoV-2 transmission for the county where the health care facility is located. The four levels are low, moderate, substantial, and high. If the two indicators suggest different transmission levels, the tool defaults to the higher level.


SARS-CoV-2 illness severity criteria were adapted from National Institutes of Health COVID-19 treatment guidelines.

**Mild illness:** People 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.

**Moderate illness:** People who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) greater than or equal to 94% on room air at sea level.

**Severe illness:** People who have respiratory frequency of more than 30 breaths per minute; SpO2 less than 94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of more than 3%); ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) less than 300 mmHg; or lung infiltrates greater than 50%.

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

In pediatric patients, radiographic abnormalities are common and for the most part should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.
**Severely immunocompromised:** For the purposes of this guidance, CDC uses the following definition:

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count less than 200, combined primary immunodeficiency disorder, and receipt of prednisone more than 20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of transmission-based precautions.

- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of transmission-based precautions.

- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

**Resources**


- [Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19](https://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html)

- [Clarification of Staffing Options for Congregate Care Facilities Experiencing Staff Shortages](https://www.health.state.mn.us/diseases/coronavirus/hcp/staffoptions.html)


- [CDC: If You Are Sick or Caring for Someone](https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html)

- [Rapid IgM/IgG SARS-CoV-2 Tests](https://www.health.state.mn.us/diseases/coronavirus/hcp/sarscov2test.pdf)