Risk Assessment and Public Health Management of Health Care Personnel with Potential Exposure to Residents with COVID-19 in Long-term Care, Nursing Home, and Assisted Living Settings

GUIDANCE AS OF MARCH 20, 2020

Exposure Risk Assessment

Long-term care, nursing home, and assisted living settings are responsible for working with the Minnesota Department of Health (MDH) to identify all health care personnel\(^1\) who come into contact\(^2\) with a resident having a confirmed case of COVID-19. Each of these health care professionals will undergo a risk assessment based on current CDC guidance to categorize their exposure to the case resident as low-, medium-, and high-risk.


The facility is responsible for conducting the initial risk assessment and communicating findings with MDH.

**Facility-led initial exposure risk assessment for facility-based health care personnel**

*Initial exposure risk assessment should occur as soon as possible* after contact with a confirmed case is recognized. The assessment must be conducted through an active process that includes an interview with the facility-based health care personnel. Passive reporting (e.g., use of log sheet) of PPE adherence and breaches by health care personnel is not acceptable. An example risk assessment is available from MDH. Contracted or visiting health care professionals need to be reported to MDH. The facility is not expected to perform an exposure risk assessment on contracted or visiting health care professionals.

The facility is responsible for informing health care personnel that MDH will be contacting them regarding their exposure.

Communication of medium- and high-risk exposures to MDH should include:

- Names, phone numbers, and email addresses of health care personnel.
- Information must be provided to MDH within 24 hours of identification.

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1 Health care personnel includes all facility-based staff, contracted or visiting health care professionals (e.g., lab techs, contracted physicians, visiting home health staff, visiting hospice staff), or volunteers.
2 Resident contact includes direct resident contact and brief interactions. Examples of brief interactions include: brief conversations at triage desk, briefly entering the resident room regardless of direct contact with resident or resident’s secretions/excretions, and entering the resident room immediately after the resident was discharged.
Communication of low-risk exposures to MDH should include:

▪ Total number of health care personnel having low-risk contact with the resident.
▪ Information must be provided to MDH **within 3 business days** of identification.

If MDH does not receive the contact information within the specified timeframe, MDH will communicate with the facility point of contact within 24 hours of the deadline.

**Ongoing Health Care Worker Monitoring for Settings with Confirmed COVID-19 Residents**

Facilities are expected to conduct **daily or end-of-shift exposure risk assessments** for health care personnel having repeated/ongoing contact with a resident diagnosed with confirmed COVID-19. When health care personnel first contact the COVID-19 resident, the initial exposure risk assessment process outlined above should be followed.

The daily or end-of-shift exposure assessment should occur each day the health care personnel have contact with the resident. The exposure risk assessment must be conducted through an **active process** that includes a health care worker interview. Passive reporting (e.g., use of log sheet) of PPE adherence and breaches by health care personnel is **not acceptable**. An example risk assessment is available from MDH.

Communication to MDH regarding medium- and high-risk exposures identified through ongoing exposure risk assessment should include:

▪ Names, phone numbers, and email addresses of health care personnel.
▪ Information must be provided to MDH **within 24 hours** of identification.

Communication to MDH regarding low-risk exposures identified through ongoing exposure risk assessment should include:

▪ Dates of most recent exposure to the resident for all health care personnel who have had contact with the resident.
▪ This list must be provided to MDH **at least once weekly**.

If MDH does not receive the contact information within the specified timeframe, MDH will communicate with the facility point of contact within 24 hours of the deadline.

**Care Coordination, Discharge, or Transfer Planning for Confirmed COVID-19 Residents**

Before a confirmed COVID-19 resident is discharged or transferred, facilities must inform MDH of the plan for care transition. MDH needs to be informed if plans include transfer to another health care facility, orders for home or hospice care services, or medical transport. During care transitions, facilities will be expected to communicate with the receiving facility, agency, or medical transport service to plan appropriate precautions to reduce disease transmission.
Health Care Personnel Monitoring Management

Public Health Management

Once the risk assessment has been completed and a risk level has been established for health care personnel who had contact with the resident, MDH will perform the following actions.

▪ For medium-risk exposures, MDH will inform health care personnel of restrictions on their activities, including exclusions from work, explain the active monitoring process, and provide a phone number to reach MDH 24/7. MDH will conduct daily symptom monitoring and follow up by email. With health care worker permission, daily symptom monitoring information can be shared with facility staff responsible for overseeing occupational/employee health.

▪ For high-risk exposures, MDH will inform health care personnel of restrictions on their activities (voluntary quarantine), including exclusions from work, explain the active monitoring process, and provide a phone number to reach MDH 24/7. MDH will conduct daily symptom monitoring and follow up phone. With health care worker permission, daily symptom monitoring information can be shared with facility staff responsible for overseeing occupational/employee health.

MDH recommends that all workers who have been exposed and classified as medium or high risk be excluded from work for 14 days. With that recommendation, employees are given a letter explaining their employment protections under Minnesota state law (Minnesota Statutes section 144.4196). Employees have the right to stay in home isolation/quarantine for 14 days and exclude themselves from work. CDC allows for employers who have exhausted other staffing options to ask asymptomatic employees if they would like to continue to work; however, it is the employee’s right to make that choice.

Facility Management

Each facility will be expected to ensure that employees undergoing monitoring have the capability to monitor their health status (e.g., access to a thermometer). If COVID-19 testing is necessary, facilities are expected to assist in coordination of specimen collection, unless the health care personnel chooses to seek care elsewhere.

▪ For low-risk exposures, the facility is expected to provide health care personnel with the MDH low risk fact sheet by email and explain self-monitoring of their health. If an employee having a low-risk exposure develops fever or respiratory symptoms, they should be excluded from work immediately, and the facility should notify MDH within 24 hours.

▪ For all medium- and high-risk exposure personnel, the facility must maintain awareness of health care personnel symptom and health status and assist in coordination of testing if necessary.