Responding to and Monitoring COVID-19 Exposures in Health Care Settings

12/8/2021

CDC has updated their recommendations for health care workers. Updated recommendations can be found at [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-assesment-hcp.html).

MDH is working to update this guidance.

Exposure risk assessment and monitoring

Health care organizations should identify, manage, and monitor health care workers (HCW) with workplace and community exposures to people with confirmed COVID-19 disease. This approach calls for timely identification of HCW who have contact with a coworker, patient, visitor (e.g., parent of pediatric patient), congregate care resident, or household or community member who has confirmed COVID-19, beginning two days before onset of the infected person’s symptoms. Potential exposures should be identified and assessed in all health care settings including hospitals, emergency departments, outpatient clinics, home health services, long-term care facilities and assisted living facilities, or any facility where patient care is provided.

In health care settings, potential exposure includes direct patient contact as well as brief interactions with coworkers or patients/residents with confirmed COVID-19 disease. Examples of brief interactions include brief conversations at the triage desk; briefly entering the patient or resident room, regardless of direct contact with the case or case’s secretions/excretions; and entering the case room immediately after the case is discharged.

When a potential exposure is identified, a structured risk assessment should be conducted, with individual employees receiving recommendations for health monitoring, voluntary quarantine, and social distancing, as relevant. Details on how to monitor are explained below; exposure risk categories are found on the Center for Disease Control and Prevention website: [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-assesment-hcp.html).

Identifying and excluding those who have had higher-risk exposures should be conducted in parallel with other mitigation strategies, including employee health screening, universal masking for source control, strict enforcement of excluding ill workers, and education covering infection prevention, appropriate personal protective equipment (PPE) use, and social distancing in the workplace and community. Higher-risk exposures
include an occupational interaction while not using all appropriate PPE according to CDC risk assessment criteria, or prolonged close contact with a social or household contact who has COVID-19.

Health care facilities should inform HCW who have been exposed to COVID-19, promptly conduct a risk assessment, exclude unvaccinated HCW with higher-risk exposures from patient care activities, and notify patients who have been exposed to HCW with COVID-19, as appropriate.

Initial exposure risk assessment

**Assessment of initial exposure risk should occur as soon as possible** after contact with a confirmed COVID-19-positive person is recognized. When facility resources allow, the assessment should be conducted through an active process that includes an interview with the health care worker. Details on the risk levels are found on CDC’s website, [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html). Passive reporting (e.g., use of log sheet) of personal protective equipment adherence and breaches by HCW should be used only if resources are not available to actively assess exposure risk.

The facility should inform HCW of their exposure and risk level.

**Ongoing health care worker monitoring for settings with confirmed COVID-19 inpatients or residents**

Daily or end-of-shift exposure risk assessments should be conducted for HCW having repeated/ongoing contact with an inpatient or resident diagnosed with confirmed COVID-19. The first time a health care worker has contact with a COVID-19 positive patient or resident, an initial exposure risk assessment should be conducted.

The daily or end-of-shift exposure assessment should occur each day the health care worker has contact with the positive patient or resident. If facility resources allow, the exposure risk assessment should be conducted through an active process that includes a health care worker interview.

Protecting health care workers during widespread community transmission

Widespread community transmission puts all health care workers at some risk for exposure to COVID-19, whether in the workplace or in the community. When community transmission is more prevalent, it may become unmanageable for an individual health care organization to conduct contact tracing and risk assessment of all health care workers potentially exposed to a patient, resident, or coworker with confirmed COVID-19. If facilities have exhausted all options for targeted contact tracing, risk assessment, and exclusion, they should prioritize efforts to identify recognized exposures (e.g., PPE breaches), institute monitoring of health care workers for fever and symptoms, and strictly deter health care workers from working while ill (“presenteeism”). Facilities could consider this approach if they have sufficient personal protective equipment (PPE) to ensure that higher-risk exposures are unlikely and have the ability to actively assess PPE breaches after every employee’s shift. All facilities should continue to exclude ill staff.

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Management of exposed health care workers

Once the risk assessment has been completed and a risk level has been established for HCW who had contact with a person with confirmed COVID-19, the facility should perform the following actions.

- For lower-risk exposures, the facility should provide HCW with the MDH lower-risk exposure fact sheet\(^2\), and explain self-monitoring for symptoms. If an employee having a lower-risk exposure develops symptoms consistent with COVID-19, they should be excluded from work immediately.

- For all higher-risk exposures, the facility should provide HCW with the MDH higher-risk exposure fact sheet\(^3\), 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.

HCW, regardless of vaccination status, who have had a higher-risk exposure should be tested immediately upon recognition of a case (but not earlier than two days after the exposure) and, if negative, five to seven days after the exposure. 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 the household member is no longer considered infectious). If signs or symptoms develop at any time in the 14 days following exposure, HCW should seek testing and isolate at home.

Management of exposed fully vaccinated health care workers

Fully vaccinated HCW who remain asymptomatic do not need to quarantine following a COVID-19 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). Health care workers who return to work in that time must wear a medical-grade face mask for source control at all times.

Facilities with adequate staffing should consider excluding fully vaccinated health care workers who experience household exposures.

- After the emergence of the Delta variant, data collected through the MDH HCW monitoring program suggest that risk of infection exposure to a household contact is high, regardless of vaccination status. From June 20 – Aug. 16, 2021, there was no significant difference in the proportions of fully vaccinated health care workers and unvaccinated health care workers who tested positive following a household or social exposure (27% versus 32%, respectively). In short, the Delta variant has been shown to be highly transmissible, even in populations with high vaccination rates.\(^4\)

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\(^2\) Health Care Worker Monitoring for COVID-19 Low-risk Exposure (health.state.mn.us/diseases/coronavirus/hcp/lowrisk.pdf)

\(^3\) Health Care Worker Monitoring for COVID-19 High-risk Exposure (health.state.mn.us/diseases/coronavirus/hcp/highrisk.pdf)

Management of exposed 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 quarantine and be excluded from work for 14 days. Staff may be asked to return to work during quarantine if other options have been exhausted to address a staffing shortage. Health care workers who return to work during quarantine must wear a medical-grade face mask for source control at all times. Follow MDH recommendations for inviting unvaccinated health care workers to work in the 14 days after a higher-risk exposure at [COVID-19 Recommendations for Health Care Workers](https://www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf).

There are employment protections for a person who chooses to stay away from work because of a health department recommendation. According to [Minnesota Statues, section 144.4196, Employee Protection](https://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 isolation or quarantine recommendations. CDC guidance allows employers who have exhausted other staffing options to ask asymptomatic employees to continue working during quarantine; however, it is the employee’s right to decline that request and follow isolation and quarantine guidance.

Best practices for health care facilities

- All health care workers, regardless of vaccination status, should be tested for SARS-CoV-2 when symptomatic after a higher-risk exposure, or when working in a facility experiencing an outbreak. Post-exposure testing should occur immediately upon identification of the case (but not earlier than two days after exposure) and at day five to seven after exposure, and facilities should assist in coordinating specimen collection, unless health care workers choose to get care elsewhere.

- Institute universal masking of all health care workers for source control. In light of PPE limitations, universal masking may be instituted in a tiered, risk-based approach. If this approach is used, begin in areas with highest exposure risk (e.g., emergency departments, urgent care, and emergency medical services) and patient vulnerability (e.g., those in intensive care and people who are immunocompromised). Universal masking is intended to protect both patients and employees from infected health care workers who may shed virus into the environment before onset of symptoms. Health care workers should be reminded that universal masking does not excuse their working with signs or symptoms of illness, however mild.


- Institute use of eye protection (e.g., face shield, goggles) as a way to reduce COVID-19 exposure risk. Eye protection is recommended, at a minimum, for all routine outpatient, acute care, and long-term care encounters when PPE supplies allow. Use of all appropriate PPE can reduce the number of exposures for which exclusion from work is recommended.

  - CDC COVID Data Tracker: COVID-19 Integrated County View ([https://covid.cdc.gov/covid-data-tracker/#county-view](https://covid.cdc.gov/covid-data-tracker/#county-view)). 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 relaxation of source control and distancing for fully vaccinated health care workers.

- Refer to CDC: Interim Infection Prevention and Control Recommendations link above.

- The CDC COVID Data Tracker (link above) 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.

- According to CDC guidance, fully vaccinated health care workers may dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing, as long as no unvaccinated health care workers or other unvaccinated people are present and the health care facilities are located in counties with low to moderate community transmission, as defined by the CDC COVID Data Tracker (link above).

- Institute symptom monitoring facility-wide. Enforce policies preventing health care workers from reporting to work while ill and mandate departure if symptoms develop mid shift. Health care organizations should institute policies to ensure that health care workers feel financially and socially supported for taking sick leave.

- Fully vaccinated asymptomatic health care workers may be exempt from expanded screening testing in health care facilities (e.g., routine staff testing in long-term care facilities).

- Develop social distancing policies that are enforced throughout the facility. Discourage congregating in work areas (e.g., nurse stations, workstations) and in recreation areas (e.g., break rooms, cafeterias). These policies may consider staff vaccination status, as appropriate.

- Enforce strict hand hygiene policies throughout the facility and monitor compliance.

- Dedicate staff to rigorous cleaning/disinfection of high-touch areas (e.g., doorknobs, computer terminals, phones, etc.).

- Ensure that all personnel performing aerosol-generating procedures have access to a fit-tested N95 mask or higher level respiratory protection. Follow extended use or reuse guidance, as outlined by CDC.\(^5\)

- Investigate recognized exposures of higher risk (e.g., PPE breaches) to confirmed or suspected SARS-CoV-2 patient infections (refer to 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). Examine and report clusters of employee illness to identify concerning exposures and ongoing transmission risk (refer to reporting recommendations below).

- Investigate recognized patient or resident exposures to COVID-19-positive health care workers. Anyone with prolonged close contact (within 6 feet for at least 15 minutes), beginning two days before a positive health care worker’s symptom onset date or specimen collection date, is considered exposed.

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▪ Notify patients or residents of the exposure situation.

▪ Exposed patients or residents who are still admitted should be placed into transmission-based precautions, if PPE allows, and monitored for onset of COVID-19 until 14 days after their last exposure to the test-positive health care worker.

▪ Ensure prompt notification of all health care workers and responders who are involved in the care of a test-positive COVID-19 patient. Health care facilities, emergency medical services (EMS), and transporting agencies should develop communication plans to ensure other first responders, such as police and fire departments, are notified of any positive test results.

▪ 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 health care workers around travel, and the course of action that will be taken (e.g., testing, 14-day quarantine) for health care workers who participate in nonessential travel. Visit Public Health Guidance for Potential COVID-19 Exposure Associated with Travel (www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html).

▪ For more recommendations and things to consider before, during, and after travel, visit Protect Yourself & Others: Traveling (www.health.state.mn.us/diseases/coronavirus/prevention.html#travel).

**Recommended incidents to report to MDH**

Health care organizations should report the following to MDH.

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**Long-term care facilities: Cases in residents and staff of long-term care facilities must be reported through the online form:** Submitting Clinical Information on Long Term Care COVID-19 Cases and Reporting Discrepant Laboratory Results (https://redcap-c19.web.health.state.mn.us/redcap/surveys/?s=H8MT9TTNCD).

**Known or suspected COVID-19 transmission within the health care setting.**

Clusters of COVID-19-like illness that fall into one of the following categories: ⁶

▪ Two or more cases of confirmed COVID-19 in patients seven or more days after admission for a non-COVID-19 condition with an epidemiological link within 10 days of each other.

▪ Or three or more cases of confirmed COVID-19 in health care personnel with an epidemiological link within 10 days of each other.

▪ Or three or more cases of confirmed COVID-19 in a combination of patients and health care personnel in a single unit, ward, or care team within 10 days of each other.

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References


Wear a mask. Wash your hands. Stay 6 feet from others. Stay home if you feel sick.

Minnesota Department of Health | health.mn.gov | 651-201-5000
625 Robert Street North PO Box 64975, St. Paul, MN 55164-0975
Contact health.communications@state.mn.us to request an alternate format.