Healthcare personnel exposure risk assessment guidance

As resources permit, healthcare facilities should promptly resume formal healthcare personnel (HCP) risk assessments for exposure to COVID-19 using the updated NJDOH Risk Assessment Algorithm located at https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml. 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/residents, 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 to identify 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.

If staffing shortages occur, it might not be possible to exclude exposed HCP from work. Healthcare facilities should include their occupational health program, if applicable, in the assessment and management of risk. Refer to the Strategies to mitigate HCP staffing shortages section, below.

HCP testing results guidance (molecular detection and rapid antigen testing only, not serology)

1) COVID-19 Positive HCP
   a) Asymptomatic HCP with laboratory-confirmed COVID-19: Due to the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. Asymptomatic HCP who have tested positive for COVID-19 may return to work using one of the below two strategies:
      i) **Time-based strategy**: Asymptomatic HCP who have tested positive for COVID-19 may return to work 10 days after their first positive COVID-19 test AND have had no subsequent symptoms. If symptoms develop, refer to the “Symptomatic HCP Tested Positive” criteria, below.
      ii) **Test-based strategy**: Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens).
   b) Symptomatic HCP with laboratory confirmed COVID-19: Symptomatic HCP who have tested positive for COVID-19 may return to work once one of the following criteria have been met:
      i) **Symptom-based strategy**: 10 days after symptoms first developed AND 3 days (72 hours) after fever has resolved without the use of fever-reducing medications with a significant improvement in respiratory symptoms (whichever period is longer).
      ii) **Test-based strategy**: Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) AND resolution of fever, without use of fever-reducing medication AND improvement in respiratory symptoms.

Upon meeting the return to work criteria, all HCP who have tested positive or diagnosed with COVID-19 should adhere to the following guidance:

- 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.
A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19. Of note, N95 or other respirators with an exhaust valve might not provide source control.

- After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
- Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms of COVID-19 (re)occur or worsen.

2) COVID-19 Negative HCP
   a) Asymptomatic HCP tested negative: No restrictions based on COVID-19 test results. HCP should continue to report recognized exposures, regularly monitor themselves for fever and symptoms of COVID-19, use facemasks for source control, and should not report to work when ill.
   b) Symptomatic HCP tested negative: Symptomatic HCP who test negative for COVID-19 may have another respiratory virus. Similar guidance on infection prevention and control should be followed (e.g., isolate from others, practice good hand hygiene, clean and disinfect environmental surfaces, etc.). If HCP have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis. At minimum HCP should be excluded from work for at least 24 hours after symptoms resolve including fever, if applicable. Consult your facilities occupational health policy for return to work after illness criteria.

Note: These are current recommendations based on available data and CDC guidelines. Facilities who wish to use an extended time frame for return to work, given the needs of their unique patient populations and available resources, may do so at their discretion.

Strategies to mitigate HCP staffing shortages

Facilities experiencing severe staffing shortages due to work exclusions related to COVID-19, may consider alternative strategies to mitigate those shortages. The CDC provides guidance for contingency and crisis capacity strategies at [https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html). Facilities considering implementing these strategies should consult CDC guidance and public health authorities to assure appropriate implementation. Additional considerations include:

- Maintain staffing internally (e.g., extra shifts, extra pay, contact staffing agencies).
- Review and implement executive directives, waivers, and guidance, available on the COVID-19 Temporary Operational Waivers and Guidelines page at [https://www.nj.gov/health/legal/covid19/](https://www.nj.gov/health/legal/covid19/). NJDOH has issued various guidance and waivers to address some of the challenges facilities are facing. Routine monitoring of this page is encouraged as it is continuously updated.
- Partner with other facilities within the area or corporation.
- Review existing pandemic influenza and disaster preparedness plans for resource allocation references.
- Utilize the Medical Reserve Corps (contact the local health department and Office of Emergency Management in your jurisdiction).

Resources


1 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, and volunteer personnel).

2 Detecting viral RNA via PCR testing does not necessarily mean that infectious virus is present. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

3 These strategies are applicable to both symptomatic HCP with suspected or confirmed COVID-19 HCP.