Coronavirus Disease 2019 (COVID-19)
VDH Guidance for Assessing and Managing Exposed, Asymptomatic Healthcare Personnel

**Background:** Updated guidance recommends that contact tracing and work restrictions resume in healthcare settings in communities where capacity exists to perform these activities without compromising critical infection prevention and control functions. Communities and individual facilities must consider the degree of community transmission of SARS-CoV-2 and the resources available for contact tracing. More setting-specific guidance exists for certain facilities, such as nursing homes, in which routine testing of staff is recommended based on the extent of the virus in the community. **This guidance applies to healthcare personnel (HCP) exposed in healthcare settings other than nursing homes.** Continued screening for symptoms of COVID-19 and universal source control for HCP and for others entering healthcare facilities is recommended in [CDC’s Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease (COVID-19) Pandemic](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-prevention-control.html).

**Purpose:** This tool is intended to assist with exposure assessment and work restriction decisions for HCP with potential exposure to COVID-19 in healthcare settings. It is based on [CDC’s 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-managing-sars-cov-2-exposure.html) (last updated on January 21, 2022) and [Updated Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-prevention-control.html) (February 2, 2022) and is subject to change as more guidance becomes available. Work restriction for HCP with higher-risk exposure depends on the staffing capacity and may change if a healthcare facility moves to contingency or crisis staffing standards.

**Special Circumstances:** Exposures of concern not explicitly outlined in this guidance should be considered on a case-by-case basis. Specific information on testing of HCP who work in a facility experiencing an outbreak can be found [here](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-managing-sars-cov-2-exposure.html). This guidance may also be used to evaluate exposures to HCP from a person with suspected COVID-19. If test results for a suspected case are not expected to return within 48 to 72 hours, work restrictions in this guidance may be applied until results are available. If results will be unavailable for more than 72 hours, then the work restrictions described in this document should be applied.

For situations where HCP are exposed to multiple risk factors for transmission (e.g., if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated), facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators. Further guidance on this can be found in [CDC’s Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-prevention-control.html).

This guidance applies specifically to HCP with potential exposures in a healthcare setting to patients/residents, visitors or other HCP with confirmed COVID-19. However, HCP could be exposed in the community, during travel, or at home. HCP with travel or community exposure should consult their occupational health program for guidance on the need for work restrictions. In general, HCPs with prolonged close contact with someone with COVID-19 infection at home or in the community should be managed as described for higher-risk exposure.

It is also possible for infected HCP to potentially expose their patients or other HCP in healthcare settings. In this situation, the local health department and/or healthcare facility should conduct a risk assessment to identify the HCP’s close contacts (including any patients) who were within 6 feet for a total of 15 minutes or more during a 24-hour period or had direct exposure to the HCP’s respiratory secretions, starting 2 days before onset (or specimen collection date, if asymptomatic) until the HCP was isolated. The form on subsequent pages of this document does not apply to this situation or risk assessment, as PPE worn by the infected HCP is not taken into consideration when determining who is a close contact of the infected HCP because the PPE is designed to protect the wearer, not the potentially exposed.

**HCP:** For the purposes of this document, HCP include, but are not limited to, paid or unpaid persons serving as 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
Performing Risk Assessment and Monitoring: Report all confirmed and suspected cases of COVID-19 to the local health department (LHD). If available, the occupational health or infection control programs at healthcare facilities should work in collaboration with their LHD to perform a risk assessment of potentially exposed staff.

Those staff who meet exposure criteria, as outlined in the table on Page 7, will need to be monitored for signs or symptoms of COVID-19 for 14 days after the exposure. The LHD can assist with monitoring by enrolling the staff in an automated daily monitoring and symptom tracker program, the VA Sara Alert System, or the occupational health program can opt to perform independent staff monitoring and report outcomes to the LHD.

Revisions:

On February 9, 2022, revisions were made to reflect updated document dates. Clarified when antigen testing is preferred for HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

On January 25, 2022, revisions were made to update quarantine guidance for HCPs, and update linked resources. In general, asymptomatic HCP with a higher-risk exposure who are not up to date on COVID-19 vaccination, are permitted to return to work 7-10 days after exposure, as long as they remain asymptomatic and do not test positive for SARS-CoV-2. Defined differences in work restrictions for up to date vs not up to date HCP. Definition of higher-risk exposure was updated to include use of a facemask (instead of a respirator) by HCP if the infected patient is not also wearing a facemask or cloth mask. Updated recommended testing cadence for asymptomatic, up to date HCP with a higher-risk exposure.

On October 7, 2021, revisions were made to update quarantine and testing guidance for vaccinated HCPs, discuss screening and testing for HCPs with household exposures, and update linked resources.

On May 5, 2021, revisions were made to the testing recommendations for fully vaccinated HCP with higher-risk exposures. Asymptomatic HCP with a higher-risk exposure should be tested for SARS-CoV-2, regardless of their vaccination status. Also, the timing of testing close contacts was revised to be consistent with CDC recommendations. Guidance was changed to immediately test upon identification as a close contact and again five to seven days after exposure if the first test is negative and the close contact does not have symptoms.

On April 9, 2021, revisions were made to update quarantine recommendations for individuals who are fully vaccinated and/or who have recovered from COVID-19 within the past three months. Individuals who meet all criteria are not required to quarantine. Fully vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work, except in special circumstances.

On December 18, 2020, revisions were made to update language on the recommended routine testing of nursing home staff and revision dates of CDC guidance documents. Also, updated the recommended timeframe for testing exposed, asymptomatic HCP (changed from approximately 1 week after exposure to 5 days or more after exposure), and added the resource VDH’s Interim Recommendations for Duration of Quarantine for Healthcare Personnel.

On November 5, 2020, revisions were made to update revision dates for CDC guidance documents, the duration of prolonged close contact (changed from 15 minutes to a total of 15 minutes), and the recommended timeframe for testing exposed, asymptomatic HCP (changed from 5-7 days after exposure to approximately 1 week after exposure).
### I. Interview Information

Date of Assessment: **MM / DD / YYYY**

Facility conducting the assessment?
- Facility of potential exposure
- Local Health Department

Facility Address: _____________________________________________________________

Name of Person Conducting the Assessment: _________________________________

Phone number: __________________________

Email address: __________________________

Who is providing information about the healthcare worker?

- [ ] Self (the healthcare worker)
- [ ] Other, specify person and reason: _________________________________________
II.  Healthcare Personnel (HCP) Contact Information

*Note: The healthcare personnel who had contact with a COVID-19 case-patient will be hereafter referred to as HCP.*

Last Name: ____________________________  First Name: ____________________________

DOB: ______________  Age: ______  Sex:  • Male  • Female

Race:  • White  • Black or African American  • American Indian or Alaskan Native  • Asian  • Native Hawaiian or Other PI

Ethnicity:  • Not Hispanic or Latino  • Hispanic or Latino

Home Street Address: ______________________________________________________

Apt. # ______________  City: __________________________  County: ____________  State: ______

Phone number: __________________________

Email address: __________________________

Emergency Contact:

Last Name: ____________________________  First Name: ____________________________

Phone Number: __________________________
### III. COVID-19 Case-Patient Information

*If the HCP was exposed to multiple COVID-19 patients, complete a separate form for each exposure.*

At the time of this assessment, is the COVID-19 patient:  □ Confirmed  □ Probable  □ Unknown

Was your exposure to the COVID-19 patient in a U.S. Facility?  □ Yes  □ No

- If No, in what country was the exposure? ________________________________

Facility Name: ________________________________

Facility Type: ________________________________

Street Address: ________________________________

City: ____________________________  County: ____________________________  State: ________________

Occupational Health or Primary Contact: ________________________________

Phone number: ________________________________

Is/was the COVID-19 patient:

- □ Inpatient  □ Outpatient  □ Employee  □ Family member visiting a patient

- □ Non-family visitor to a patient  □ Unknown  □ Other: ____________________________

Date of illness onset of COVID-19 case: MM / DD / YYYY

**Notes:**
## IV. Exposures to a COVID-19 Infected Patient/Resident

1. **Does the HCP meet both** of the following criteria?  
   - **Up to date**\(^1\) with COVID-19 vaccination  
   - Has remained asymptomatic since the COVID-19 exposure  
   - **Yes**  
   - **No**  
   - **Unsure**

2. **Does the HCP meet all three** of the following criteria?  
   - Recovered from SARS-CoV-2 infection  
   - Within 3 months of initial infection with SARS-CoV-2  
   - Has remained asymptomatic since the COVID-19 exposure  
   - **Yes**  
   - **No**  
   - **Unsure**

3. Date of visit or admission date of the COVID-19 confirmed patient/resident:  
   - Discharge date, if applicable:  
   - Date of death, if applicable:  
   - MM / DD / YYYY

4. At any time during the patient/resident’s stay, while you **were not** wearing a respirator or facemask\(^2\), did you have any prolonged close contact\(^3,4\) with the case?  
   - **Yes**  
   - **No**  
   - **Unsure**

5. At any time during the patient/resident’s stay, while the patient/resident **was not** wearing a facemask or cloth face covering and while you **were not** wearing a respirator, did you have any prolonged close contact\(^3,4\) with the case?  
   - **Yes**  
   - **No**  
   - **Unsure**

6. At any time during the patient/resident’s stay, while the patient/resident **was not** wearing a facemask or cloth face covering and while you **were not** wearing eye protection (face shield or goggles), did you have any prolonged close contact\(^3,4\) with the case?  
   - **Yes**  
   - **No**  
   - **Unsure**

7. At any time during the patient/resident’s stay while you **were not** wearing all recommended PPE\(^5\) (i.e., gown, gloves, eye protection, respirator) did you perform an aerosol-generating procedure (AGP)\(^6\) (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, sputum induction)?  
   - **Yes**  
   - **No**  
   - **Unsure**

8. At any time during the patient/resident’s stay did you have unprotected direct contact\(^7\) with infectious secretions or excretions?  
   - **Yes**  
   - **No**  
   - **Unsure**

9. List date(s) (or date range) when you had contact with the patient/resident or their secretions/excretions. *(Use additional paper to capture all dates, if needed)*  
   - MM / DD / YYYY

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\(^1\) HCP are considered “up to date” if they have received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.
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 our assessment of risk. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown.

For HCP potentially exposed in healthcare settings, 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. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol-generating procedure.

For HCP potentially exposed in healthcare settings, data are limited for the definition of close contact. For this guidance CDC defines it as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

PPE = personal protective equipment. PPE for performing an AGP on a person with confirmed or suspected COVID-19 includes: N95 respirator or equivalent, eye protection (goggles or face shield), gown, and gloves.

There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for healthcare settings. Commonly performed medical procedures that are often considered AGPs include: Open suctioning of airways, sputum induction, cardiopulmonary resuscitation, endotracheal intubation and extubation, non-invasive ventilation (e.g. BiPap, CPAP), bronchoscopy and manual ventilation. It is uncertain whether aerosols generated from some procedures may be infectious, such as nebulizer administration and high flow oxygen delivery. For additional information on aerosol-generating procedures, please see: Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J (2012) Aerosol Generating Procedures and Risk of Transmission of Acute Respiratory Infections to Healthcare Workers: A Systematic Review. PLoS ONE 7(4); https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338532/#!po=72.2222

This refers to unprotected direct contact with infectious secretions or excretions or the mucous membranes.
# Coronavirus Disease 2019 (COVID-19)
## VDH Guidance for Assessing and Managing Exposed, Asymptomatic Healthcare Personnel

## Work Restriction* and Testing Recommendations for Asymptomatic Healthcare Personnel Following Exposure to Patients/Residents, Visitors, or Other HCP with Confirmed COVID-19

<table>
<thead>
<tr>
<th>Recovered from COVID-19 &amp; Meets Criteria</th>
<th>HCP Up to Date &amp; Meets Criteria</th>
<th>Type of Exposure in Healthcare Facility</th>
<th>PPE Used by HCP</th>
<th>Facemask or Face Covering Used by Patient/Resident</th>
<th>Work Restrictions*</th>
<th>Testing Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Any</td>
<td>Any</td>
<td>Yes or No</td>
<td>● No work restrictions are generally necessary. ● Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection. ● Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.</td>
<td>Testing is not recommended unless symptoms develop</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Higher-risk exposure to a person with confirmed COVID-19</td>
<td>Any</td>
<td>Yes or No</td>
<td></td>
<td>Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 5–7 days after the exposure</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>Lower-risk: Exposure risk other than those described above (e.g., brief conversation at triage desk, briefly entering a patient/resident room but not having direct or close contact, having brief body contact with the patient/resident)</td>
<td>Any</td>
<td>Yes or No</td>
<td></td>
<td>Testing is not recommended unless symptoms develop</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Higher-risk exposure to a person with confirmed COVID-19&lt;sup&gt;5, 6&lt;/sup&gt;</td>
<td>Yes or No</td>
<td>HCP not wearing a respirator nor facemask</td>
<td>Exclude from work following one of two options: 1) Return to work after day 7 following the exposure if a viral test is negative for SARS-CoV-2 and HCP does not develop symptoms. 2) Return to work after day 10 following the exposure if HCP does not develop symptoms. In addition to work exclusion: ● Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19 and not reporting to work when ill or if testing positive for SARS-CoV-2 infection. ● Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Higher-risk exposure to a person with confirmed COVID-19&lt;sup&gt;5, 6&lt;/sup&gt;</td>
<td>No</td>
<td>HCP wearing a facemask</td>
<td>● If planning to return to work after day 7 following the exposure, collect and test within 48 hours before the time of planned return to work. ● If planning to return to work after day 10 following the exposure, healthcare facilities could consider testing for SARS-CoV-2 within 48 hours before the time of planned return, but a test is not required.</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Higher-risk exposure to a person with confirmed COVID-19&lt;sup&gt;5, 6&lt;/sup&gt;</td>
<td>Yes or No</td>
<td>HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, N95 respirator) while performing an aerosol-generating procedure (AGP) and/or surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (i.e., surgical procedures involving anatomic regions with high viral loads such as the oropharynx or nose)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Higher-risk exposure to a person with confirmed COVID-19&lt;sup&gt;5, 6&lt;/sup&gt;</td>
<td>No</td>
<td>HCP not wearing eye protection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Coronavirus Disease 2019 (COVID-19)

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| No | No | Lower-risk: Exposure risk other than those described above (e.g., brief conversation at triage desk, briefly entering a patient/resident room but not having direct or close contact, having brief body contact with the patient/resident) | Any | Yes or No | ● No work restrictions necessary  
● Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.  
● Any HCP who develop fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.  
Testing is not recommended unless symptoms develop |

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**Note:** HCP with travel or community exposures should inform their occupational health program for guidance on the need for work restrictions.

1. Work restriction for HCP with higher-risk exposure depends on the staffing capacity and may change if a healthcare facility moves to contingency or crisis staffing standards.

2. "Recovered from COVID-19 and Meets Criteria" means the HCP meets all of the following criteria: a) recovered from COVID-19; b) within 3 months of initial infection with SARS-CoV-2; c) has remained asymptomatic since the COVID-19 exposure.

3. "Up to Date and Meets Criteria" means the HCP meets both of the following criteria: a) received all recommended COVID-19 vaccines, including any booster dose(s) when eligible; and b) has remained asymptomatic since the COVID-19 exposure.

4. Work restrictions might be recommended under the following circumstances:
   a) HCP who are moderately to severely immunocompromised (e.g., organ transplantation, cancer treatment)
   b) When directed by public health authorities (e.g., during an outbreak where SARS-CoV-2 infections are identified among HCP who are up to date with all recommended COVID-19 vaccines).

5. HCP who are not up to date with COVID-19 vaccination who have recently recovered from COVID-19, for whom there is concern that their initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result (e.g., individual was asymptomatic, antigen test positive, and a confirmatory NAAT was not performed), should still consider work restriction for 7-10 days after higher-risk exposure (duration depends on whether the HCP has a negative test collected and tested within 48 hours before the time of planned return to work).

6. Higher-risk exposure is considered prolonged close contact with a patient/resident, visitor, or HCP with confirmed SARS-CoV-2 infection. These exposures generally involve exposure of the HCP’s eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if the HCP was present in the room for an aerosol-generating procedure. It is reasonable to consider an exposure of 15 minutes or more as prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol-generating procedure. Close contact is defined as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

7. Determining the time period when the patient/resident, visitor, or HCP with confirmed COVID-19 would have been infectious:
   a) For symptomatic cases: 2 days prior to symptom onset through the time period when the individual meets the criteria for discontinuation of Transmission-Based Precautions.
   b) For asymptomatic cases: either 2 days after their exposure, if known, until they meet criteria for discontinuing Transmission-Based Precautions or 2 days prior to positive specimen collection through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.

8. Other exposures classified as lower-risk, including having body contact with the patient/resident (e.g., rolling the patient/resident) 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. Factors associated with these exposures should be evaluated on a case-by-case basis.

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**Additional Information:**

- **Testing:**
  - Testing is recommended when the HCP presents with symptoms consistent with COVID-19 or when the HCP is required by the employer to test. Testing is not recommended unless symptoms develop.
  - Testing is recommended when the HCP is required by the employer to test. Testing is not recommended unless symptoms develop.

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**References:**