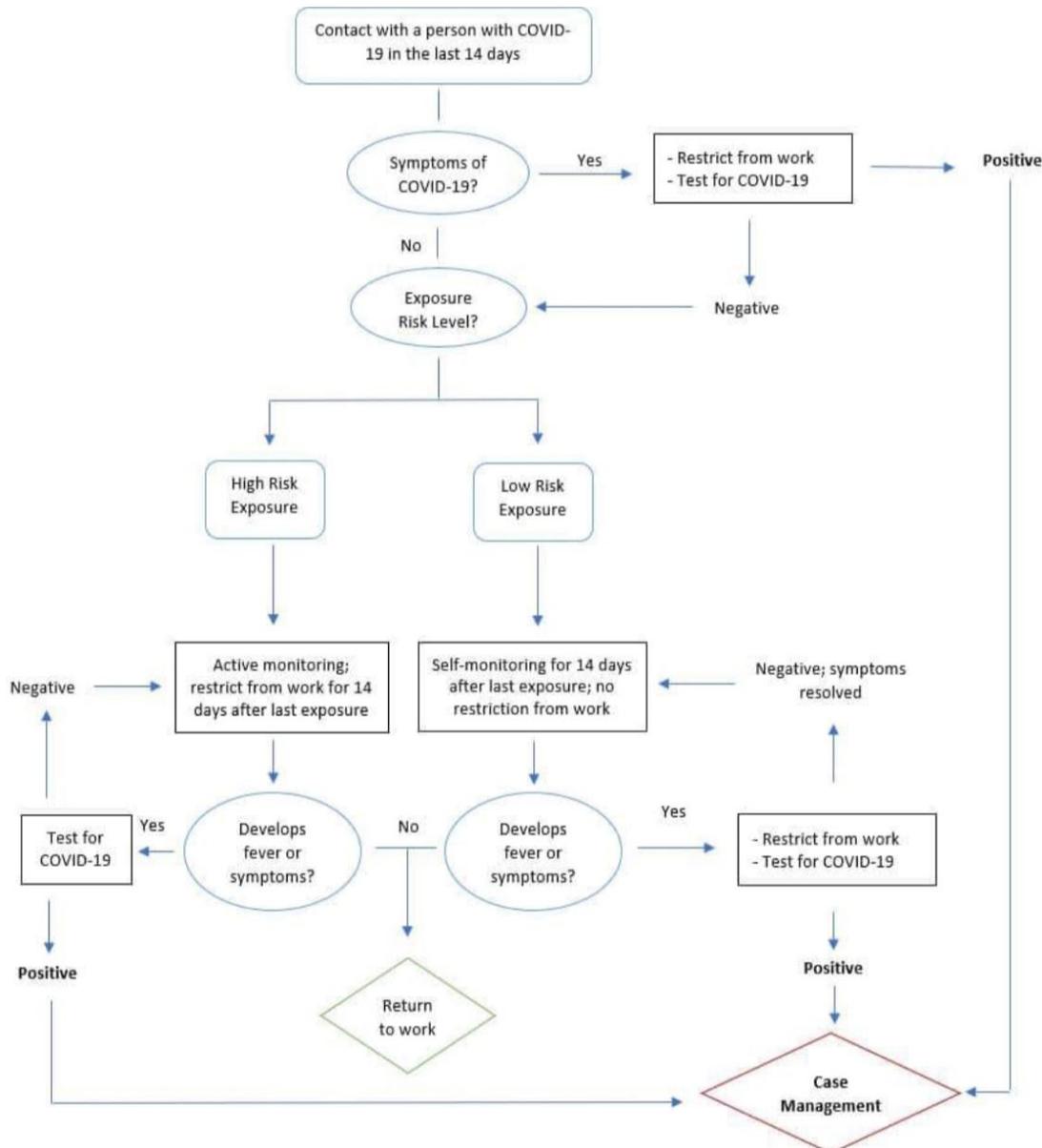




Assessment of a Provider/Employee with a COVID19 Exposure and Return to Work Analysis

Use this CDC chart as a baseline and consider the below-listed factors Influencing Exposure Risk Level to COVID-19 Confirmed or Suspected individual.



Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/public-health-management-hcw-exposed.html>



Factors Influencing Exposure Risk Level to COVID-19 Confirmed or Suspected Individual:

The following list of factors (not exhaustive) should be considered by the Compliance, Clinical, and Operational Leadership teams conducting case-by-base risk assessments, as they can increase or decrease the level of risk in a given exposure scenario:

- Duration of exposure. (Exposure time longer than 15 minutes can increase risk, while brief interactions may have lower risk).
 - Community exposure that is considered prolonged is defined as 15 minutes or longer at <6ft.
- Type of interaction/ whether there was close contact
 - Any duration of exposure should be considered prolonged if the exposure occurred during performance of an aerosol-generating procedure (AGP)
 - ****Close contact is defined as a) being within approximately 6 feet (2 meters) of a 2019-nCoV suspected or confirmed individual for a prolonged period of time while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, mask/respirator, eye protection). Close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a 2019-nCoV case or having direct contact with infectious secretions of a 2019-nCoV case (e.g., being coughed on) while not wearing recommended personal protective equipment.**
- Extent of body contact (contact with infectious body fluids, particularly **oral and respiratory secretions can increase risk**).
- Clinical presentations of COVID-19 confirmed or suspected individual symptoms/ (Coughing and severe illness can increase risk).
- COVID-19 confirmed or suspected individuals wearing a mask properly for the entirety of the interaction. (Proper wearing of mask during the entirety of interaction can lower risk).
- DHCP not following proper practices of donning (putting on) and doffing (taking off) PPE can increase risk.
- Not performing diligent hand hygiene can increase risk.
- PPE was soiled, damp, damaged or inconsistently worn (can increase risk).
- Other individual and context-based factors.



- NOTE: As a crisis capacity the CDC permits allowing **asymptomatic HCP** who have had an unprotected exposure to SARS-CoV-2 but are not known to be infected to continue to work.
 - Consider:
 - “Essential” nature of the DHCP
 - Staffing shortages
 - Number of dental emergencies
 - In the event of returning to work as crisis capacity the following must be complied with:
 - These HCP should still report temperature and absence of symptoms each day before starting work. (NOTE: This is the overarching DEPG practice-wide policy as part of the DEPG Safe Work Place Plan.)
 - Continue to wear masks **at all times** in non-patient areas. (NOTE: This is the overarching DEPG practice-wide policy as part of the DEPG Safe Work Place Plan.)
 - If DHCP develops even mild symptoms consistent with COVID-19, they must cease patient care activities and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.
- If DHCP are tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all Return to Work Criteria (unless they are allowed to work as described above for crisis capacity ONLY).

DHCP who tests positive for COVID-19 must be excluded from work and return as per the criteria below

CDC’s Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

Symptomatic HCP with suspected or confirmed COVID-19 (Either strategy is acceptable depending on local circumstances):

- *Symptom-based strategy.* Exclude from work until:



- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed *since symptoms first appeared*
- *Test-based strategy*. Exclude from work until:
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - 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). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

- *Time-based strategy*. Exclude from work until:
 - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.
- *Test-based strategy*. Exclude from work until:
 - 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). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Note that detecting viral RNA via PCR** does not necessarily mean that infectious virus is present.



Consider consulting with local infectious disease experts when making return to work decisions for individuals who might remain infectious longer than 10 days (e.g., severely immunocompromised).

If HCP had COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

Source: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

***** For more information on COVID-10 testing please see attached FAQs and Tips on COVID-19 Testing and a publication from the Texas Department of State Health Services, explaining the types of testing currently available.***