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| SEAL_v2008-07_web%20large | **Commonwealth of Massachusetts** |
| ***Executive Office of Health and Human Services*** |
| **Department of Youth Services** |
| **Risk Assessment and Public Health Management of Youth and Employees with Potential Exposure to COVID-19 in a DYS Residential Program** |

The purpose of this guidance is to assist regional administrative management and regional health services in DYS residential facilities with assessment of risk, monitoring, and work restriction decisions for employees with potential exposure to COVID-19. In addition, this guidance is intended to assist with risk assessment and public health management of youth with potential exposure to COVID-19 in a DYS residential program.

All staff and youth in DYS residential settings have the potential for direct or indirect exposure to ill persons or infectious materials, including body substances, contaminated medical supplies, devices, and equipment, contaminated environmental surfaces, and contaminated air. For COVID-19 purposes, epidemiologic risk factors and recommended monitoring for COVID-19 identified for Healthcare Personnel (HCP) will apply to staff and youth in DYS residential programs.

This protocol is based on the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19). DYS staff and youth in residential programs are considered to be HCP in a healthcare setting for the purposes of this guidance which is based on currently available data about COVID-19. Recommendations regarding which staff are restricted from work may not anticipate every potential scenario and will change if indicated by new information.

Please regularly check the below link for updates:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

**I. Definitions Used in this Guidance**

***Self-monitoring*** means the staff and youth should monitor themselves for fever by taking their temperature twice a day and remain alert for symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)\*. Staff on self-monitoring should notify their supervisor and DYS HR if they develop fever or respiratory symptoms during the self-monitoring period. Youth should notify DYS staff.

***Self-Monitoring with delegated supervision***means staff and youth perform self-monitoring with oversight by regional administrative management for employees and health services staff for youth in coordination with the health department of jurisdiction. On the days staff are scheduled to work, they must successfully pass the entrance screening according to the DYS COVID-19 Screening Protocol prior to starting work.

Regional administrative management and health services staff should establish points of contact between DYS, the self-monitoring employee/youth, and the local or state health departments of authority in the location where the employee/youth will be during the self-monitoring period. This communication should result in agreement on a plan for medical evaluation of an employee or youth who develops fever or symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)\* during the self-monitoring period. The Regional administrative management/health services staff should remain in contact with the employee/youth through the self-monitoring period and arrange for timely and appropriate follow-up if symptoms should develop.

***Active monitoring*** means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed persons to assess for the presence of fever or symptoms of COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)\*.

***Close contact*** is defined as follows: a) being within approximately 6 feet (2 meters) of a person with COVID-19 for a prolonged period of time (such as sitting within 6 feet of the ill person in a room ); or b) having unprotected direct contact with infectious secretions or excretions of the ill person (e.g., being coughed on, touching used tissues with a bare hand). Close contact can occur while caring for, living with, visiting, or sharing a room with a COVID-19 case while the case was symptomatic or within the 48 hours before symptom onset.

*Note,* data are limited for definitions of close contact. Factors for consideration include the duration of exposure (e.g., longer exposure time likely increases exposure risk), clinical symptoms of the ill person (e.g., coughing likely increases exposure risk) and whether the ill person was wearing a cloth face covering or facemask (which helps block respiratory secretions from contaminating others and the environment), PPE used by personnel, and whether aerosol generating procedures were performed.

*Note,* data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it is reasonable to consider an exposure greater than a few minutes as a prolonged exposure. Brief interactions are less likely to result in transmission; however, clinical symptoms of the ill person and type of interaction (e.g., did the ill person cough directly into the face) remain important. Recommendations will be updated as more information becomes available.

*Note,* risk stratification can be made in consultation with public health authorities. Examples of brief interactions include: briefly entering a room without having direct contact with the ill person or their secretions/excretions, a brief conversation over a desk with an ill person who was not wearing a cloth face covering or facemask. See Table 1 for more detailed information.

#### II. Defining Exposure Risk Category

While body fluids other than respiratory secretions have not been clearly implicated in transmission of COVID-19, unprotected contact with other body fluids, including blood, stool, vomit, and urine, might put a staff or youth at risk of COVID-19.

Table 1 describes possible scenarios that can be used to assist with risk assessment. These scenarios do not cover all potential exposure scenarios and should not replace an individual assessment of risk for the purpose of clinical/professional decision making or individualized public health management. Any public health decisions that place restrictions on an individual’s or group’s movements or impose specific monitoring requirements should be based on an assessment of risk for the individual or group. Regional administrative management/health services staff, in consultation with public health authorities, should use the concepts outlined in this guidance along with clinical/professional judgment to assign risk and determine need for work restrictions.

For this guidance, high-risk exposures refer to staff/youth who have had prolonged close contact with persons ill with COVID-19 (beginning 48 hours before onset of symptoms) who were not wearing a cloth face covering or facemask while their nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., nebulizer therapy) on an ill person with COVID-19 (beginning 48 hours before onset of symptoms) when the staff/youth eyes, nose, or mouth were not protected, is also considered high-risk.

Medium-risk exposures generally include staff/youth who had prolonged close contact with persons ill with COVID-19 (beginning 48 hours before onset of symptoms) who were wearing a cloth face covering or facemask while their nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Some low-risk exposures are considered medium-risk depending on the type of care activity performed. For example, staff who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during a nebulizer treatment would be considered to have a medium-risk exposure. If a nebulizer treatment had not been performed, they would have been considered low risk. See Table 1 for additional examples.

Low-risk exposures generally refer to brief interactions with persons ill with COVID-19 (beginning 48 hours before onset of symptoms) or prolonged close contact with persons ill (beginning 48 hours before onset of symptoms) who were wearing a cloth face covering or facemask for source control while staff/youth were wearing a facemask. Use of eye protection in addition to a facemask would further lower the risk of exposure.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect staff/youth having prolonged close contact with persons infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, staff/youth should still perform self-monitoring with delegated supervision.

Staff/youth with no direct contact to ill persons and no entry into an area occupied by an ill person who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have no identifiable risk).

Currently, this guidance applies to staff/youth with potential exposure to persons with confirmed COVID-19. However, staff/youth exposures could involve a Person Under Investigation (PUI) who is awaiting testing. Implementation of monitoring and work restrictions described in this guidance could be applied to staff/youth exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of staff/youth exposed to a PUI should be maintained and staff/youth should be encouraged to perform self- monitoring while awaiting test results. If the results will be delayed more than 72 hours or the ill person is positive for COVID-19, then the monitoring and work restrictions described in this document should be followed.

**Table 1: Epidemiologic Risk Classification1 for Asymptomatic Healthcare Personnel (HCP) Following Exposure to Patients with Coronavirus Disease 2019 (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations**

**DYS staff and youth in residential programs are considered to be HCP in a healthcare setting for the purposes of this protocol.**

The highest risk exposure category that applies to each person should be used to guide monitoring and work restrictions.

Note:  While respirators confer a higher level of protection than facemasks when caring for patients with COVID-19, facemasks do confer protection that was factored into our assessment of risk.

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| Epidemiologic risk factors | **Exposure category** | **Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*** | **Work Restrictions for Asymptomatic HCP** |
| Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who was WEARING a cloth face covering or facemask (i.e., source control) |
| HCP PPE: None | Medium | Active | Exclude from work for 14 days after last exposure |
| HCP PPE: Not wearing a facemask or respirator | Medium | Active | Exclude from work for 14 days after last exposure |
| HCP PPE: Not wearing eye protection | Low | Self with delegated supervision | None |
| HCP PPE: Not wearing gown or gloves[a](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#a) | Low | Self with delegated supervision | None |
| HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator) | Low | Self with delegated supervision | None |
| Prolonged close contact with a patient with COVID-19 (beginning 48 hours before symptom onset) who was NOT WEARING a cloth face covering or facemask (i.e., no source control) |
| HCP PPE: None | High | Active | Exclude from work for 14 days after last exposure |
| HCP PPE: Not wearing a facemask or respirator | High | Active | Exclude from work for 14 days after last exposure |
| HCP PPE: Not wearing eye protection[b](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#b) | Medium | Active | Exclude from work for 14 days after last exposure |
| HCP PPE: Not wearing gown or gloves[a](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#a),[b](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#b) | Low | Self with delegated supervision | None |
| HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)[b](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#b) | Low | Self with delegated supervision | None |

HCP=healthcare personnel; PPE=personal protective equipment

aThe risk category for these rows would be elevated by one level if staff/youth had extensive body contact with the ill person (e.g., restraint, assault).

bThe risk category for these rows would be elevated by one level if staff/youth performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., nebulizer therapy). For example, staff who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure.

Additional Scenarios:

* Refer to the footnotes above for scenarios that would elevate the risk level for exposed staff/youth. For example, staff who were wearing a gown, gloves, eye protection, and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure.
* Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect staff/youth having prolonged close contact with persons ill with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, staff/youth should still perform self-monitoring with delegated supervision.
* Staff/youth not using all recommended PPE who have only brief interactions with an ill person regardless of whether the ill person was wearing a cloth face covering or facemask are considered low-risk. Examples of brief interactions include:  brief conversation at a desk; briefly entering a room but not having direct contact with the ill person or their secretions/excretions.
* Staff/youth who walk by an ill person or who have no direct contact with the ill person or their secretions/excretions and no entry into the ill person’s room are considered to have no identifiable risk.

#### III. Recommendations for Monitoring Based on COVID-19 Exposure Risk

**Staff in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their primary care provider) for medical evaluation prior to returning to work**

1. **High- or Medium-risk Exposure Category**
**Staff in the high- or medium-risk category** should undergo active monitoring, including restriction from work until 14 days after their last exposure. If they develop any fever (measured temperature >100.0oF\* or subjective fever (feeling feverish) OR symptoms consistent with COVID-19  (e.g., cough, shortness of breath, sore throat, myalgias, malaise),\* they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and their supervisor promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation. DYS Human Resources is to be notified by Regional Administrative Management.
2. **Low-risk Exposure Category
Staff in the low-risk category** should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic staff in this category are not restricted from work. They should check their temperature twice daily and remain alert for symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat, myalgias, malaise)\*. They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or symptoms consistent with COVID-19, they may report to work. If they develop fever (measured temperature > 100.0 oF\* or subjective fever (feeling feverish) OR symptoms consistent with COVID-19 they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and supervisor promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation. Regional Administrative Management is to notify DYS Human Resources.
3. **Staff who Adhere to All Recommended Infection Prevention and Control Practices**Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect staff having prolonged close contact with persons infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, staff should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.
4. **No Identifiable risk Exposure Category**
**Staff in the no identifiable risk category** do not require monitoring or restriction from work.
5. **Community or travel-associated exposures**
Staff with [community-](https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html) or [travel-associated](https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html) exposures to COVID-19  should inform their supervisor that they have had a community or travel-associated exposure. Decisions about restriction from work should be made in consultation with state or local health authority with DYS HR notified. Staff who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their primary care provider) for medical evaluation prior to returning to work.

**Additional Considerations and Recommendations:**

\* Fever is either measured temperature >100.0oF or subjective fever. Note that fever may be intermittent or may not be present in some persons, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical/professional judgment should be used to guide testing of persons in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0oF) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by regional administrative staff/health services staff or public health authorities.  Additional information about clinical presentation of patients with COVID-19 is [available](https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html).