HealthCap
RISK MANAGEMENT SERVICES

STRATEGIES TO MITIGATE STAFFING SHORTAGES AND CRISIS STAFFING CONSIDERATIONS

Goal:
To assist in mitigating healthcare personnel staffing shortages that may occur due to COVID-19 exposure/infection.

Rationale:
Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these.

These are **Contingency and Crisis Capacity Strategies** that healthcare facilities should consider in these situations.

Contingency Capacity to Mitigate Staffing Shortages

Rationale:
When staffing shortages are anticipated, facilities will use contingency capacity strategies to plan and prepare for mitigating this problem and will:

1. **Identify** staffing needs and number of staff to provide safe work environment and resident care
2. **Communicate** with local health care coalitions, federal, state, and local health partners to identify additional HCP when needed
3. **Adjust** staff schedules, hire, and rotate staff to positions to support resident care activities
    a. Cancel all non-essential procedures and visits; shift staff to support resident care after needed orientation and training.
    b. Address factors that might prevent staff from reporting to work such as housing and transportation.
    c. Identify other HCP to work in facility based on waivers/changes to licensure.
    d. Request HCP to postpone elective time off from work
4. **Develop** a regional plan to identify a designate facility/alternate care site with adequate staff to care for residents with COVID-19.
5. **Develop** plans to allow asymptomatic HCP who have had unprotected exposure to COVID-19 to continue to work.
    a. HCP monitors temperature and absence of symptoms prior to work.
    b. Wear facemask while at work for 14 days after exposure; should not use cloth face covering during this period.
        i. Facemask does not replace need for N95 when indicated
        ii. N95/respirators with exhaust valves may not provide source control

   c. If symptoms develop, even mild, HCP will cease work and notify supervisor prior to leaving work.
6. **Prioritize** HCP with suspected COVID-19 for testing
7. **Develop** criteria to determine which HCP with suspected or confirmed COVID-19, who are well enough to work, could return to work before meeting return to work criteria* if shortages continue despite other strategies. Consider:
   a. Type of HCP shortage needed
   b. Where HCP are in the course of their illness (viral shedding is higher in early course of illness)
   c. Symptoms they are experiencing
   d. Degree of interaction with residents and other staff.
   e. Type of residents they care for (i.e. immunocompromised residents)
8. Facility, along with risk management, should create a message for residents and HCP about actions that will be taken to protect them from exposure if staff with suspected or confirmed COVID-19 return to work.

Crisis Capacity Strategies to Mitigate Staffing Shortages

Rationale:
When staffing shortages occur and there is no longer enough staff to provide patient care, facilities may need to implement crisis capacity strategies to continue to provide residents care.

1. Implement regional plans to transfer residents positive with COVID-19 to designated facilities/alternate care sites with adequate staffing
2. Continue or begin allowing asymptomatic HCP who had unprotected exposures to continue to work with guidelines Contingent Capacity/Crisis Strategies protocol.
3. If staffing shortages continue despite mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are well enough to work but have not met return to work criteria*. If allowed, they should not have contact with severely immunocompromised residents (transplant, hematology-oncology) and prioritize duties in this order:
   a. Duties where they do not interact with others
   b. Provide direct care only for residents with confirmed COVID-19
   c. Provide direct care for residents with suspected COVID-19
   d. As a last resort, provide direct care for residents without suspected or confirmed COVID-19.
2. If HCP are permitted to return prior to meeting all return to work criteria*, they will adhere to all return to work practices and work restrictions:
   a. Wear facemask at all times while in facility until all symptoms are resolved or 14 days after illness onset, whichever is longer. (No cloth face covering during this time.)
      i. Facemask does not replace need for N95 when indicated

   ii. N95/respirators with exhaust valves may not provide source control
b. Remind staff that in addition to potentially exposing residents, they could expose co-workers.
   i. Facemasks should be worn even in non-resident care areas such as break rooms
   ii. If facemask must be removed, in order to eat or drink, they should separate themselves from others.
c. Should be restricted from contact with severely immunocompromised residents until the full return to work criteria* has been met.
d. Self-monitoring for symptoms, leave patient care area and seek re-evaluation if respiratory symptoms recur or worsen.

***Return to Work Criteria for HCP with Confirmed or Suspected 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:

1. At least 3 days (72 hours) have passed since recovery defined as resolution without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**
2. At least 10 days have passed since symptoms *first appeared*

Test-based strategy:

- Resolution of fever without the use of fever-reducing medications **and**
3. Improvement in respirator symptoms (e.g., cough, shortness of breath); **and**
4. Negative results from FDA approved assay from at least two consecutive respiratory specimens collected > 24 hours apart (total of two negative specimens)

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 *symptom-based* or *test-based strategy* should be used.

Test-based strategy. Exclude from work until:

5. Negative results from FDA approved assay from at least two consecutive respiratory specimens collected > 24 hours apart (total of two negative specimens)

Strategies to Mitigate Healthcare Personnel Staffing Shortages; April 13, 2020; https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19; April 30, 2020; https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html