# Strategies to Mitigate Healthcare Personnel Staffing

## COVID-19

CDC guidance for SARS-CoV-2 infection may be adapted by state and local health departments to respond to rapidly changing local circumstances.

This guidance provides information on strategies to mitigate healthcare personnel staffing shortages during the COVID-19 pandemic.   See history of updates.

# Summary of Recent Changes

Updates as of December 23, 2021                                                                          ⌃

**As of December 23, 2021**

Due to concerns about increased transmissibility of the SARS-CoV-2 Omicron variant, this guidance is being updated to enhance protection for healthcare personnel (HCP), patients, and visitors and to address concerns about potential impacts on the healthcare system given a surge of SARS-CoV-2 infections. These updates will be refined as additional information becomes available to inform recommended actions.

- Ensure that SARS-CoV-2 testing is performed with a test that is capable of detecting ⧉  SARS-CoV-2, even with the currently circulating variants in the United States.
- Updated contingency and crisis strategies for mitigating staff shortages.

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# Key Points
- **Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and for safe patient care.**
- **Maximizing interventions to protect HCP, patients, and visitors are critical at all times, including when considering strategies to address staffing shortages.**
- **CDC's mitigation strategies offer a continuum of options for addressing staffing shortages.** Contingency, followed by crisis capacity, strategies augment conventional strategies and are **meant to be considered and implemented sequentially** (i.e., implementing contingency strategies before crisis strategies).

## Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

HCP are considered "boosted" if they have received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC. HCP are considered "vaccinated" or "unvaccinated" if they have NOT received all COVID-19 vaccine doses, including a booster dose, as recommended by CDC.

For more details, including recommendations for healthcare personnel who are immunocompromised, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).

### Work Restrictions for HCP With SARS-CoV-2 Infection

| Vaccination Status | Conventional | Contingency | Crisis |
|---|---|---|---|
| Boosted, Vaccinated, or Unvaccinated | 10 days OR 7 days with negative test†, if asymptomatic or mildly symptomatic (with improving symptoms) | 5 days with/without negative test, if asymptomatic or mildly symptomatic (with improving symptoms) | No work restriction, with prioritization considerations (e.g., asymptomatic or mildly symptomatic) |

### Work Restrictions for Asymptomatic HCP with Exposures

| Vaccination Status | Conventional | Contingency | Crisis |
|---|---|---|---|
| Boosted | No work restrictions, with negative test on days 2‡ and 5–7 | No work restrictions | No work restrictions |
| Vaccinated or Unvaccinated, even if within 90 days of prior infection | 10 days OR 7 days with negative test | No work restriction with negative tests on days 1‡, 2, 3, & 5–7 | No work restrictions (test if possible) |

†Negative test result within 48 hours before returning to work
‡For calculating day of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0

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# Introduction

**This guidance is for healthcare facilities** that are expecting or experiencing staffing shortages due to COVID-19. Conventional strategies for return to the workplace for HCP with SARS-CoV-2 infection or higher-risk exposures are described in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC

**Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care.** As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or the 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 shortages.  These plans and processes include communicating with HCP about actions the facility is taking to address shortages, maintaining patient and HCP safety, and providing resources to assist HCP with anxiety and stress.

**CDC's mitigation strategies offer a continuum of options for addressing staffing shortages.** Contingency, followed by crisis capacity strategies, augment conventional strategies and are **meant to be considered and implemented sequentially** (i.e., implementing contingency strategies before crisis strategies). For example, if, despite efforts to mitigate, HCP staffing shortages occur, healthcare systems, facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that certain HCP with suspected or confirmed SARS-CoV-2 infection should return to work before the full conventional Return to Work Criteria have been met. Allowing HCP with SARS-CoV-2 infection or higher-risk exposures to return to work before meeting the conventional criteria could result in healthcare-associated SARS-CoV-2 transmission.

**At baseline, healthcare facilities must:**

- Ensure any COVID-19 vaccine requirements for HCP are followed, and where none are applicable, encourage vaccination, including booster dose, as recommended by CDC.
- Understand their normal staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care under normal circumstances.
- Understand the local epidemiology of COVID-19-related indicators (e.g., community transmission levels).
- Communicate with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed.

# Contingency Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. These include:

**Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities.**

- Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation and training to work in these areas that are new to them.
- Attempt to address social factors that might prevent HCP from reporting to work, such as need for transportation or housing that allows for physical distancing, particularly if HCP live with individuals with underlying medical conditions or older adults.
    - Consider that these social factors disproportionately affect persons from some racial and ethnic groups, who are also disproportionally affected by COVID-19 (e.g., African Americans, Hispanics and Latinos, and American Indians and Alaska Natives).
- Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
- As appropriate, request that HCP postpone elective time off from work. However, there should be consideration for the mental health benefits of time off and that care-taking responsibilities may differ substantially among staff.

**Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection.**

**Allowing asymptomatic HCP who 1) had a higher-risk exposure to SARS-CoV-2 and 2) are not known to be infected with SARS-CoV-2 and 3) have not received all COVID-19 vaccine doses, including booster dose, as recommended by CDC, to continue to work onsite throughout their 14-day post-exposure period:**

If permitted to work, these HCP should be tested* 1 day after the exposure (day 0) and, if negative, again 2, 3, and 5-7 days after the exposure. If testing supplies are limited, testing should be prioritized for 1-2 days after the exposure and, if negative, 5-7 days after exposure.

*Either an antigen test or nucleic acid amplification test (NAAT) can be used.  Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT.  Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

- These HCP should still report temperature and absence of symptoms each day before starting work.
- They should use a respirator or well-fitting facemask at all times in the facility.
- If HCP develop even mild symptoms consistent with COVID-19, they should either not report to work, or stop working and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.
- If HCP are tested and found to be infected with SARS-CoV-2, they should ideally be excluded from work until they meet all Return to Work Criteria. HCP with suspected SARS-CoV-2 infection should be prioritized for testing, as testing results will impact when they may return to work and for which patients they might be permitted to provide care.

**Allowing HCP with SARS-CoV-2 infection who are well enough and willing to work to return to work as follows:**

HCP with mild to moderate illness who are *not* moderately to severely immunocompromised:

- At least 5 days have passed *since symptoms first appeared* (day 0), **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.

Healthcare facilities may choose to confirm resolution of infection with a negative antigen test or NAAT*.

HCP who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 5 days have passed since the date of their first positive viral test (day 0).

Healthcare facilities may choose to confirm resolution of infection with a negative antigen test or NAAT*.

*Either an antigen test or NAAT can be used when referenced in the criteria above. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period.  Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT.  Antigen testing is preferred for symptomatic HCP and for asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

- Considerations for determining which HCP should be prioritized for this option include:
  - The type of HCP shortages that need to be addressed.
  - Where individual HCP are in the course of their illness (e.g., viral shedding is likely higher earlier in the course of illness).
  - The types of symptoms they are experiencing (e.g., persistent fever, cough).
  - Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
  - The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than immunocompromised patients).
- If HCP are permitted to return to work before meeting all conventional Return to Work Criteria, they should still adhere to the recommendations described below.
  - Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.
  - HCP should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
    - A respirator or well-fitting facemask should be worn continuously even when they are in non-patient care areas such as breakrooms.
    - They should practice physical distancing from coworkers at all times.
    - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
    - They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.

# Crisis Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages occur, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care:

Implement regional plans to transfer patients with COVID-19 to designated healthcare facilities, or alternate care sites with adequate staffing

Allow asymptomatic HCP who 1) had a higher-risk exposure to SARS-CoV-2 and 2) are not known to be infected with SARS-CoV-2 and 3) have not received all COVID-19 vaccine doses, including booster dose, as recommended by CDC, to continue to work onsite throughout their 14-day post-exposure period without testing.

- These HCP should still report temperature and absence of symptoms each day before starting work.
- They should use a respirator or well-fitting facemask at all times in the facility.
- If HCP develop even mild symptoms consistent with COVID-19, they should either not report to work, or stop working and notify their supervisor or occupational health services prior to leaving work. These individuals should be prioritized for testing.
- If HCP are tested and found to be infected with SARS-CoV-2, they should ideally be excluded from work until they meet all Return to Work Criteria. HCP with suspected SARS-CoV-2 infection should be prioritized for testing, as

testing results will impact when they may return to work and for which patients they might be permitted to provide care.

**If shortages continue despite other mitigation strategies, as a last resort consider allowing HCP to work even if they have suspected or confirmed SARS-CoV-2 infection, if they are well enough and willing to work, even if they have not met all Return to Work Criteria.**

- Considerations for determining which HCP should be prioritized for this option include:
  - The type of HCP shortages that need to be addressed.
  - Where individual HCP are in the course of their illness (e.g., viral shedding is likely to be higher earlier in the course of illness).
  - The types of symptoms they are experiencing (e.g., persistent fever, cough).
  - Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?
  - The type of patients they care for (e.g., consider patient care only with patients known or suspected to have SARS-CoV-2 infection rather than immunocompromised patients).
- Healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is operating under crisis standards, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill critical staffing needs.
- If HCP are requested to work before meeting all criteria, they should be restricted from contact with moderately to severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:
  - If not already done, allow HCP with suspected or confirmed SARS-CoV-2 infection to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in telemedicine services.
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with confirmed SARS-CoV-2 infection, preferably in a cohort setting.
  - Allow HCP with confirmed SARS-CoV-2 infection to provide direct care only for patients with suspected SARS-CoV-2 infection.
  - As a last resort, allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients *without* suspected or confirmed SARS-CoV-2 infection. If this is being considered, this should be used only as a bridge to longer term strategies that do not involve care of uninfected patients by potentially infectious HCP. Strict adherence to all other recommended infection prevention and control measures (e.g., use of respirator or well-fitting facemask for source control) is essential.
- If HCP are requested to return to work before meeting all Return to Work Criteria, they should still adhere to recommendations described below.
  - Patients (if tolerated) should wear well-fitting source control while interacting with these HCP.
  - HCP should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
    - A respirator or well-fitting facemask should be worn even when they are in non-patient care areas such as breakrooms.
    - They should practice physical distancing from coworkers at all times.
    - If they must remove their respirator or well-fitting facemask, for example, in order to eat or drink, they should separate themselves from others.
    - They should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.

## Definitions

**Facemask**: OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as "medical procedure masks." Facemasks should be used according to product labeling and local, state, and

federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators, including those intended for use in healthcare are certified by the CDC/NIOSH.

# Previous Updates

## Updates from Previous Content ⌃

**As of March 10, 2021**

- Guidance addressing work restriction considerations for fully vaccinated HCP was moved to Infection Control after Vaccination

**As of February 16, 2021**

- Added, as contingency strategies options to allow:
    - Asymptomatic HCP who have had a higher-risk exposure to SARS-CoV-2 (the virus that causes COVID-19) but are not known to be infected to shorten their duration of work restriction as described in Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing.
    - Asymptomatic fully vaccinated HCP who have had a higher-risk exposure to SARS-CoV-2 but are not known to be infected to continue to work onsite throughout their 14-day post-exposure period.

**As of December 14, 2020**

- Incorporated reference to Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing

**As of July 17, 2020**

- Referenced Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2, which provides considerations for performing post-exposure testing of HCP exposed to SARS-CoV-2

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