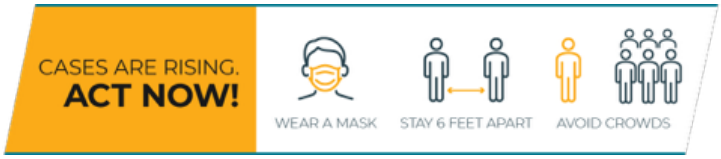
COVID-19 (Coronavirus Disease)



Strategies to Mitigate Healthcare Personnel Staffing Shortages

Updated Dec. 14, 2020 Print

Summary of Recent Changes

Updates as of December 14, 2020

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

View Previous Updates

Who is this for: Healthcare facilities that may be experiencing staffing shortages due to COVID-19

What is it for: To assist healthcare facilities in mitigating healthcare personnel staffing shortages that might occur because of COVID-19.

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe 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, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety and providing resources to assist HCP with anxiety and stress.

There are Contingency and Crisis Capacity Strategies that healthcare facilities should consider in these situations. 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 HCP with suspected or confirmed COVID-19 could return to work before the full Return to Work Criteria have been met. Several of the Crisis Capacity Strategies are dependent on HCP wearing a facemask for source control while at work. Given ongoing shortages of personal protective equipment (PPE), facilities should refer to and implement relevant Strategies for Optimizing the Supply of Facemasks.

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. At baseline, healthcare facilities must:

- Understand their staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care.
- Be in communication with local healthcare coalitions, 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 for healthcare facilities 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 social distancing, particularly if HCP live with individuals with underlying medical conditions or older adults.
    - Consider that these social factors disproportionately affect persons from racial and ethnic groups 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 consideration for the mental health benefits of time off and that the burden of the disease and care-taking responsibilities may differ substantially among certain racial and ethnic groups.

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

Developing plans to allow asymptomatic HCP who have had high risk unprotected exposure to SARS-CoV-2 (the virus that causes COVID-19) but are not known to be infected to continue to work onsite during their 14-day post-exposure period. CDC has provided Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing. These options could be considered as a measure to mitigate staffing shortages and not as a preferred option. Healthcare facilities should understand that shortening the duration of work restriction might result in additional transmission risks. Healthcare facilities management that elect to implement approaches other than those described in the CDC scientific brief should understand that there might be additional transmission risks posed by their approach.

These plans should not be implemented until facilities are using crisis standards.

- These HCP should still report temperature and absence of symptoms each day before starting work.
- These HCP should wear a facemask (for source control) while at work for 14 days (this is the time period during which exposed HCP might develop symptoms, i.e., the current incubation period for the virus) after the exposure event. A facemask instead of a cloth mask should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
    - A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed SARS-CoV-2 infection.
- If HCP develop 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 HCP 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. 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.

Developing criteria to determine which HCP with suspected or confirmed SARS-CoV-2 infection (who are well enough and willing to work) could return to work in a healthcare setting before meeting all Return to Work Criteria—if staff shortages continue despite other mitigation strategies. Implementing this is a crisis strategy and should be implemented only as a last resort when other options have been exhausted.

- Considerations 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 appears to be higher earlier in the course of illness).

  - The types of symptoms they are experiencing (e.g., persistent fever).
  - 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., immunocompromised patients or only patients with SARS-CoV-2 infection).
- As part of planning, healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is operating under crisis standards, the changes in practice that should be expected, and actions that will be taken to protect them from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are allowed to work.

Crisis Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are occurring, 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
- If not already done, implement plans (see contingency capacity strategies above) to allow asymptomatic HCP who have had a high-risk unprotected exposure to SARS-CoV-2 but are not known to be infected to continue to work.
  - If HCP 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 below).
- If shortages continue despite other mitigation strategies, as a last resort consider implementing criteria to allow HCP with suspected or confirmed SARS-CoV-2 infection who are well enough and willing to work but have not met all Return to Work Criteria to work. If HCP are allowed to work before meeting all criteria, they should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and facilities should consider prioritizing their duties in the following order:
  1. 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.
  2. 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.
  3. Allow HCP with confirmed SARS-CoV-2 infection to provide direct care for patients with suspected SARS-CoV-2 infection.
  4. 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 involve care of uninfected patients by potentially infectious HCP.

If HCP are permitted to return to work before meeting all Return to Work Criteria, they should still adhere to all Return to Work Practices and Work Restrictions recommendations described in that guidance. These include:

- Wear a facemask for source control at all times while in the healthcare facility until they meet the full Return to Work Criteria and all symptoms are completely resolved or at baseline. A facemask instead of a cloth mask should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
- They should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
    - Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
    - They should practice social distancing from coworkers at all times.
    - If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others.
- They should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until the full Return to Work Criteria have been met.
- They should self-monitor for symptoms and seeking re-evaluation from occupational health if respiratory symptoms recur or worsen.

Definitions

Cloth mask: Textile (cloth) covers are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE and it is uncertain whether cloth face coverings protect the wearer.** CDC has guidance available on design, use, and maintenance of cloth face coverings.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks 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. Facemasks that are not regulated by FDA, 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 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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Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases