



# Coronavirus Disease 2019 (COVID-19)

## Strategies to Mitigate Healthcare Personnel Staffing Shortages

**Who is this for:** Healthcare facilities who 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.

### Summary of Recent Changes as of April 30, 2020

- Updated to align with changes to [Return to Work Criteria](#)

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 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 transportation or housing if HCP live with vulnerable individuals.
- 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.
- Request that HCP postpone elective time off from work.

Developing regional plans to identify designated healthcare facilities or [alternate care sites](#) with adequate staffing to care for patients with COVID-19.

Developing plans to allow asymptomatic HCP who have had an [unprotected exposure to SARS-CoV-2](#) (the virus that causes COVID-19) but are not known to be infected to continue to work.

- 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 face covering 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 higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- 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 Prioritizing HCP with suspected COVID-19 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 COVID-19 (who are well enough to work) could return to work in a healthcare setting before meeting all [Return to Work Criteria](#)—if shortages continue despite other mitigation strategies.

- Considerations include:
  - The type of HCP shortages that need to be addressed.
  - Where 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).
- As part of planning, healthcare facilities (in collaboration with risk management) should create messaging for patients and HCP about actions that will be taken to protect them from exposure to SARS-CoV-2 if HCP with suspected or confirmed COVID-19 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, allow asymptomatic HCP who have had an [unprotected exposure to SARS-CoV-2](#) but are not known to be infected to continue to work.
  - 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 after the exposure event. A facemask instead of a cloth face covering 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 higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19

- Of note, N95 or other respirators with an exhaust valve might not provide source control.
- 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](#) (unless they are allowed to work as described below).
- If shortages continue despite other mitigation strategies, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 who are well enough 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 COVID-19 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 COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
  3. Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
  4. As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients *without* suspected or confirmed COVID-19.

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 face covering 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 higher-level respirator (or other PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- 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.
  - If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others.
- Being restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until the full [Return to Work Criteria](#) have been met.
- Self-monitoring for symptoms and seeking re-evaluation from occupational health if respiratory symptoms recur or worsen.

## Definitions

**Cloth face covering:** 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.

