



Strategies to Mitigate Healthcare Personnel (HCP) Staffing Shortages During the COVID-19 Pandemic

Prior to the implementation of contingency or crisis staffing models utilizing exposed or positive staff, healthcare facilities are to first employ contingency staffing strategies to optimize use of non-exposed, non-positive staff. Several optimization strategies are below. **This guidance is to be used in coordination with KDPH Guidance for Healthcare Personnel for Work while in COVID-19 Quarantine or Isolation.**

Contingency Staffing Strategy Checklist

Baseline Measures:

- Define the minimum number of staff needed to provide a safe work environment and safe patient care
- Communicate with local healthcare coalitions and federal, state, and local public health partners to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed
- Communicate with partners to identify alternate sites for transfer of residents if staffing becomes insufficient for safe resident care after mitigation strategies are exhausted

Contingency Staffing Strategies for Healthcare Facilities:

- Review non-essential procedures and visits and postpone them as necessary to accommodate COVID-19 patient needs
- Adjust staff schedules
- Shift HCP from non-essential procedure roles to support prioritized patient care activities
- Ensure HCP receive appropriate orientation and training to work in areas new to them
- Request that HCP postpone elective time off from work
- Identify and/or hire additional HCP to work in the facility
- Develop regional plans to identify [designated healthcare facilities](#) or [alternate care sites](#) with adequate staffing to care for patients with COVID-19
- Develop 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 are to be monitored for fever and symptoms each day before work
 - These HCP are to wear a surgical mask (or N95 if appropriate and fit tested) at all times when on the job
 - Facility should use post-exposure testing consistent with CDC guidance during the post-exposure period to quickly identify pre-symptomatic or asymptomatic HCP who could contribute to SARS-CoV-2 transmission, these test results should be available rapidly, and there should be a clear plan to respond to the results
 - Facility may use post-exposure testing to shorten the quarantine period using current [CDC guidance](#) and as adopted by [KDPH](#)



- 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](#)

When staffing shortages occur despite implementing contingency staffing strategies, healthcare facilities and employers (in collaboration with human resources and occupational health services) may need to implement crisis staffing strategies to continue providing patient care.

Any healthcare facility implementing crisis staffing strategies should communicate regularly with its local health department (LHD) of jurisdiction with regard to its staffing plans.

Crisis Staffing Strategies

- Facilities using crisis staffing strategies should inform impacted patients and HCP, as appropriate, that changes in practice may occur and that actions will be taken to protect them from exposure to SARS-CoV-2 if HCP with suspected or confirmed COVID-19 are allowed to work
- Develop criteria to determine which HCP with suspected or confirmed COVID-19 (who are well enough and willing to work) could work in a healthcare setting before meeting all [Return to Work Criteria](#) if staff shortages continue despite other mitigation strategies
Considerations include:
 - 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)
 - Types of symptoms they are experiencing (e.g., persistent fever)
 - 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?
 - Type of patients they care for (e.g., immunocompromised patients or only patients with SARS-CoV-2 infection)

If shortages continue **despite other mitigation strategies**, consider implementing criteria to allow HCP with suspected or confirmed COVID-19 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 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 meeting 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 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
- 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 (e.g., 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 seek re-evaluation from occupational health if respiratory symptoms recur or worsen

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