American Hospital Association™
Advancing Health in America

COVID-19

Acute Care Workforce Post-COVID Exposure Guide

Introduction

The purpose of this playbook is:

- To provide a collection of resources pertaining to current acute care workforce needs post-COVID exposure.
- To easily extract information and use the playbook template to disseminate new information as it becomes available in your organization.

Adapted from New Jersey Hospital Association's Healthcare Provider (HCP) COVID-19 Staffing Resource Toolkit

Staffing Post-COVID Exposure

Ensuring proper distribution and safety of medical staff is essential. Take priority of the following tasks when planning for staff capacity:

- Utilize Centers for Disease Control and Prevention (CDC) projections for individual hospitals and the region when planning for surge capacity.
- Limit the spread of COVID-19 within the hospital to protect health care workers and patients according to CDC recommendations.
- Identify ways to maintain, augment and stretch the hospital workforce.

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RECOMMENDED CLINICAL CARE TEAM MODELS

Consider the following staffing models to implement.

Hub-and-Spoke Model

- A specialty trained HCP (e.g., critical care nurse) leads a team of newly cross-trained staff and provides guidance and support to the team members.
- The team lead should coordinate closely with the staff education department to ensure rapid training and competency assessments of new staff.
- This model allows for staff flexibility in critical care settings.

COVID Primary Care Team

- A dedicated team of nurses, physicians and respiratory therapists provide care for the COVID patients.
- This approach may help conserve personal protective equipment, reduce exposures to HCP and provide COVID patients with a coordinated approach to treatment and management.

Surgical, Diagnostic and Procedural COVID Teams

- A dedicated team of HCPs to provide surgical, diagnostic and procedural care to COVID patients.
- These teams should coordinate closely with the COVID primary care team to ensure that all treatments/procedures that are ordered/performed are reviewed to ensure that they are necessary and appropriate for the treatment/management of the COVID patient.

Other Specialty Teams

- There are many other important patient and staff needs during the COVID pandemic — patient end-of-life goals of care, patient and family engagement and support, and staff resilience and morale.
- Palliative care providers, patient and family engagement advisers and spiritual leaders are critical and should coordinate with leadership to ensure these important needs are met during this difficult time.

SAMPLE TEMPLATE FOR HCP RETURN-TO-WORK POLICY (PER CDC GUIDELINES)

I. Policy

(Facility Name), in accordance with Centers for Disease Control and Prevention (CDC) guidelines, has outlined in the following policy, actions to be taken to allow health care providers (HCP) to return to work after a suspected or confirmed COVID-19 infection.

II. Procedure

1. In the event that an HCP has been infected with COVID-19, occupational health, in coordination with infection prevention, infectious disease and public health will advise the HCP of the following actions that must occur prior to returning to work within the health care setting.
2. Options for return-to-work clearance include a test-based strategy or a nontest-based strategy (e.g., time-since-illness onset and time-since-recovery strategy).

Test-based Requirements

Exclude from work until resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath), and negative results of a Food and Drug Administration emergency use-authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens).

All test results should be final before isolation is ended. Testing guidance is based on limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract (nasopharyngeal swab) specimens.

Nontest-based Requirements

Exclude from work until at least three days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and, at least seven days have passed since symptoms first appeared.

Note: If HCP were never tested for COVID-19 but have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

3. Upon meeting the aforementioned requirements, HCP must receive documented approval to return to work from occupational health.
4. After returning to work, HCP should comply with the following:
    - **Wear a face mask at all times** while in the health care facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
    - **Be restricted from contact with severely immunocompromised patients** (e.g., transplant, hematology, oncology) until 14 days after illness onset.
    - **Adhere to hand hygiene, respiratory hygiene and cough etiquette** in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles).
    - **Self-monitor for symptoms** and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.

RETURN-TO-WORK PRACTICES AND WORK RESTRICTIONS FOR HCP

After returning to work, HCP should:

- Wear face masks at all times while in the health care facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer. After this period, these HCP should revert to their facility policy regarding universal source control during the pandemic.
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology, oncology) until 14 days after illness onset.
- Adhere to hand hygiene, respiratory hygiene and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles).
- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.

Returning to work earlier than recommended:

HCP should be evaluated by occupational health to determine appropriateness of earlier return to work than recommended above in the policy. If HCP return to work earlier than recommended, they should still adhere to the return-to-work practices and work restriction recommendations. Additionally, the CDC recommends prioritizing their duties in the following order:

- 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.
- Allow HCP with confirmed COVID-19 to provide direct care only for patients with confirmed COVID-19, preferably in a cohort setting.
- Allow HCP with confirmed COVID-19 to provide direct care for patients with suspected COVID-19.
- As a last resort, allow HCP with confirmed COVID-19 to provide direct care for patients without suspected or confirmed COVID-19.

STRATEGIES TO MITIGATE STAFFING SHORTAGES

When facing staffing shortages, the CDC shares the following considerations related to return-to-work practices (as of April 13, 2020).

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 experienced (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, health care 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.
- Repurpose both clinical and nonclinical staff roles to support COVID units and coordinate training sessions to increase appropriate skill sets.
- Communicate with local health care 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.
- Implement regional plans to transfer patients with COVID-19 to designated health care facilities, isolation sites or alternate care sites with adequate staffing.

Clinical Education and Staffing Resources

From the American Association of Critical Care Nurses (AACN)

To support nurses who need to cross-train to care for patients with COVID-19, AACN offers an e-learning course to all nurses at no charge to provide vital resources during this challenging time.

From the Society of Critical Care Medicine (SCCM)

SCCM and its members are committed to supporting all clinicians on the front lines of this pandemic through the society's complimentary online training, Critical Care for Non-ICU Clinicians.

From the American Association of Colleges of Nursing (AACN)

During disasters and times of uncertainty, nurses and other health professionals can promote resilience. This presentation includes a technique to renew energy, ways to support children and strategies to decrease social isolation and foster resilience. Access the AACN webinar "COVID-19: Promoting Resilience in Times of Crisis" and other COVID topics.