

Strategies for Managing a Surge in Healthcare Provider Demand

Staff shortages may become a primary challenge in the management of patient surge during the COVID-19 pandemic. For example, healthcare providers may themselves become ill, family concerns may decrease ability of staff to work extra hours, and school closures may inhibit staff from performing normal duties. Healthcare workforce subject experts from within the U.S. Department of Health and Human Services (HHS) have identified the following strategies that local healthcare workforce decision-makers could adopt to optimize healthcare workforce assets, assess ongoing staffing needs, and identify resources to meet these needs. Ongoing and close coordination with local, county, and state public health agencies; and coordination between health care facilities will be necessary and vital throughout the course of the COVID-19 emergency. Additional resources are available online in the [COVID-19 Workforce Virtual Toolkit: Resources for Healthcare Decision-Makers Responding to COVID-19 Workforce Concerns](#).

1. Implement Policies and Practices to Maximize Existing Workforce

- Review published strategies to maximize the existing healthcare workforce:
 - [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)
 - This page from the Centers for Disease Control and Prevention (CDC) makes recommendations regarding staffing at the facility and health system level
 - [Utilize Crisis Standards of Care*](#)
 - This paper from the National Academy of Medicine discusses how decision-makers can apply crisis standards of care principles while planning workforce strategies
 - [Mitigate Absenteeism by Protecting Healthcare Workers' Psychological Health and Well-being during the COVID-19 Pandemic](#)
 - The actions listed in this document from the NRCC Healthcare Resilience Task Force can help healthcare facility leaders protect workers' psychological health and well-being
- Consider practices to optimize clinical staff capacity:
 - Provide necessary training to support the return of clinical providers in administrative positions to clinical positions
 - Rapidly up-train staff with similar skill sets to those needed for specialized care
 - Enable the expansion of clinician to patient ratios by assigning clinical providers to the most specialized care (medication administration, ventilator management) and delegating non-specialized and personal care provision (feeding, bathing) to supporting staff
 - Reassign staff from low volume or closed services (such as outpatient clinics and surgery services) to high-need units

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- Use medical or nursing students to support clinical providers in non-clinical roles
- Consider policies to increase staff ability and availability:
 - Provide child care or other resources to alleviate caretaking requirements as a barrier to staff availability
 - Emphasize staff health and safety, including through work process controls to reduce workplace exposure for all staff (clinical, environmental services, transporters, etc.) and access to [self-care resources](#) that can sustain provider well-being.
 - Address Personal Protective Equipment (PPE) concerns through training and practice to increase comfort with PPE available
 - Provide alternate housing to address concerns of exposing vulnerable family members
 - Adjust shift schedules and lengths to maximize staffing and avoid burn out
 - Provide support, information, and training on crisis standards of care being implemented to ensure comfort and adherence

2. Step Two - Quantifying Future Healthcare Workforce Needs

- Project healthcare workforce needs by cadre, type, and skill level.
 - Example workforce staffing calculators:
 - [COVID-19 Health Workforce Surge Planning*](#)
 - [COVID-19 Clinical Staff Projection Calculator*](#)
 - [COVID-19 Staffing Needs Calculator*](#)
- Reassess as the situation evolves by monitoring several factors:
 - How many additional staff are needed due to current census and acuity?
 - How many staff members are unavailable due to COVID-19 illness, health concerns, childcare needs, etc.?
 - How many additional health care providers are available from immediately accessible temporary staffing solutions:
 - Reassignment of providers from within your health system or facility
 - Staffing from contracted staffing agencies

3. Step Three - Supplement Healthcare Workforce Staff

- Local level
 - Hire needed staff through staffing agencies with which a relationship already exists

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- When limitations exist, identify additional agencies able to provide the necessary cadres
- Refer to and implement Health Care Coalition (HCC) staff sharing plans as outlined in HCC Hospital Preparedness Plans
- Consider hiring furloughed or underutilized staff from other local providers who may have reduced/discontinued nonessential medical procedures
- State resources
 - Reassign staff under Section 319 of the Public Health Service (PHS) Act
 - This provision allows a state governor, tribal leader or designee to request the [temporary reassignment](#) of state and local public health department or agency personnel funded in whole or in part through programs authorized under the PHS Act to immediately address a public health emergency
 - Leverage Reservists and National Guard
 - An important consideration is to not pull individuals currently working in a clinical setting as their full-time job
 - Identify healthcare providers in non-clinical positions who may be quickly trained to increase staffing
 - Request assistance through the [Emergency Management Assistance Compact*](#) (EMAC)
 - EMAC is a national disaster-relief compact allowing states to send personnel to assist with response and recovery efforts in other states
 - EMAC is implemented within the State Emergency Management Agency on behalf of the governor of the state
- Engaging healthcare workforce volunteers
 - Leverage state-registered healthcare provider volunteers
 - Specific options available vary by state
 - States should encourage interested volunteers to register through [ESAR-VHP](#). This program will verify a volunteer's identity, license(s), credentials, accreditations, and hospital privileges.
 - The [Medical Reserve Corps](#) (MRC) is a national network of volunteers, organized locally to improve the health and safety of their communities.
 - Local units have varying capabilities and mixes of volunteer types
 - Identify whether there is a local unit in your area and the contact information for the unit leader at <https://mrc.hhs.gov/FindMRC> to determine whether the MRC unit may be able to support the need.
 - Note that MRC units primarily respond in their local area.

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- [National Voluntary Organizations Active In Disaster](#)* (VOAD) is an association of organizations that mitigate and alleviate the impact of disasters, provides a forum promoting cooperation, communication, coordination and collaboration; and fosters more effective delivery of services to communities affected by disaster. The National VOAD coalition includes more than 100 Member organizations, which represent National members, State VOADs, Local/Regional VOADs and hundreds of other member organizations throughout the country.
- Additional volunteer resources that support wrap-around services and public health roles that do not include healthcare facility staffing needs are included in [Appendix A](#).
- Federal Government Resources
 - Note that federal resources should be requested only when other options are not available, as they are limited in availability, short-term and may complicate billing and reimbursement for local health systems
 - States requesting federal support in healthcare provider staffing should be prepared to provide specific information on the need, such as data describing the status of existing workforce resources:
 - Percentage of hospitals/jurisdictions that have implemented crisis standards of care (e.g., increased patient to healthcare worker ratios)
 - Percentage of healthcare providers practicing outside of the discipline they are licensed for (e.g., anesthesiologists to intensivists)
 - Percentage of healthcare providers reallocated (e.g., practicing outside of their usual practice site, including those relocated across state lines)
 - Number of state medical reserve corps volunteers, national guard, or DoD staff deployed for medical surge (or % of facilities/jurisdictions with those staff deployed)
 - Percentage of healthcare providers unable to practice due to quarantine or COVID infection
 - Federal response teams
 - Local authorities should work through existing emergency management (ESF-8) mechanisms to submit a request for assistance through the state

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- The ASPR Regional Emergency Coordinators (RECs) and Administrator (RAs) will work with the requestor to define the requirement and, if approved, identify the type of support needed for the response
 - a. National Disaster Medical System (NDMS) resources (see [Appendix B: Requesting NDMS resources](#) details)
 - b. U.S. Public Health Service Commissioned Corps
 - c. Military or Department of Defense teams

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Appendix A: Examples of Additional Volunteer Resources

- The Community Emergency Response Team (CERT) program educates volunteers about disaster preparedness for the hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. CERT offers a consistent, nationwide approach to volunteer training and organization that professional responders can rely on during disaster situations, allowing them to focus on more complex tasks.
 - For requests for assistance, it must be made to the local jurisdiction.
 - To check to see if there is a CERT in your area:
https://community.fema.gov/Register/Register_Search_Programs
- The American Red Cross prevents and alleviates human suffering in the face of emergencies by mobilizing the power of volunteers and the generosity of donors. Volunteer opportunities include supporting blood donations and delivering much-needed services to your community.
- [Voluntary Agency Liaisons \(VALs\)](#) are FEMA employees who support the significant contributions of voluntary, faith-based, and community stakeholders active in disaster by building relationships – and coordinating efforts – with and across partner organizations and government agencies. VALs promote information-sharing and mutual understanding among partners, and provide guidance on integrating activities across various subject areas and the full disaster life-cycle.

Appendix B: Requesting National Disaster Medical System (NDMS) resources

ASPR Regional Administrators (RAs) and [Regional Emergency Coordinators](#) (RECs) can facilitate a request for NDMS support from a state, tribal or territorial authority. Local authorities must make a request for NDMS assistance through the state. The RA or REC will work with the requestor to define the requirement and identifying the type of support needed for the response.

NDMS Teams are capable of performing a wide range of patient-care functions in a variety of mission scenarios, including but not limited to:

- primary, acute, stabilizing emergency care
- emergency department decompression
- inpatient care augmentation
- supporting patient movement
- stabilization and transfer of all patients including ill/injured and nursing home patients
- staffing casualty/patient collection points
- triage services
- mass prophylaxis

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- medical site/shelter operations

NDMS intermittent employees are federalized employees upon deployment. Similar to the military reserves, NDMS employees have regular jobs, but serve on a rotational on-call schedule and deploy as intermittent federal employees when ASPR activates them in an emergency. Team members commit to staying at the site for up to two weeks.

NDMS teams cannot support missions in state psychiatric or in prisons.

Local and State entities cannot charge for services that are being provided by the NDMS teams at their locations.

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