**Crisis Staffing Suggestions: *DRAFT***

11-15-2020

All segments of healthcare are experiencing unprecedented staff crises during the COVID-19 pandemic. This list of suggestions, compiled by MHCA from a variety of sources, may offer some guidance as your agency determines how to weather this storm. If you have questions, or additional suggestions to add to future versions of this list, please contact MHCA (contact info at end of document).

**MDH Progression of Staffing Options**

1. Call back asymptomatic quarantined staff.
	* *See suggested ways to utilize quarantined staff in Section B: Cross Training, below.*
2. Contact related facilities or partners including sister facilities and hospital partners.
	* *See further information in Section D: Relationship Building, below.*
3. Contact supplemental nurse staffing agencies.
	* *See information on contract agreements in Section D: Relationship Building, below.*
4. Contact other nearby health care facilities, partners, or local university/college health career centers.
	* *See information on developing compact agreements in Section D: Relationship Building, below.*
5. Contact your [Regional Health Care Preparedness Coordinator (RHPC)](https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html) for assistance.
	* <https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html>
6. Contact the local Medical Reserve Corps (MRC) coordinator
	* *Search for ‘Medical Reserve Corps” on your county website*
7. Explore emergency management options through your county.
	* *Search for ‘Emergency Management” on your county website*
8. [Homeland Security and Emergency Management: County Emergency Managers](https://dps.mn.gov/divisions/hsem/contact/Pages/county-emergency-managers.aspx)
	* <https://dps.mn.gov/divisions/hsem/contact/Pages/county-emergency-managers.aspx>
9. If all the options listed above have been exhausted, contact the State Healthcare Coordination Center Minnesota Healthcare Resource Call Center at 1-833-454-0149 (toll free) or 651-201-3970 (local).

**Continue reading for more resources, suggestions and information on specific aspects of managing a staffing crisis.**

**A: Shifts and Payscale**

* Move to 12-hour shifts
* Offer crisis bonus pay (salary increase and/or bonus tied to hours worked, increased risk, etc.)
* Adjust client distribution to ensure maximum efficiency to control travel time – even if this requires workers temporarily “trading clients”
* Expand telehealth visits whenever possible
	+ *See further information on telehealth in Section C: Planning*
* While CDC and some states are opening up possibilities for asymptomatic COVID+ staff to continue working in client care (typically with clients who are also COIVD+), MDH (at time of writing) is maintaining stricter standards. Monitor the MDH site for any changes – MHCA will also work to keep you current on these rulings.
* As appropriate, request that your staff postpone elective time off from work.  Balance this with the know need for the mental health benefits of time off, and that the burden of the disease and care-taking responsibilities may differ substantially among your staff members.

**B: Cross-training**

* Examine all tasks to see which could be picked up by staff in other areas to minimize in-person visits; explore the breadth of each type of licensure or certification to not miss any possibilities
* Be willing to think broadly without --- .For example, if a therapist could empty the garbage and wash some dishes, thereby allowing fewer homemaker visits, could that happen for the greater good?
* Cross train staff to cover other duties to the best of their professional abilities
* Develop and post a grid of who can cover what so that when the need arises, the information is readily available. Update grid regularly.
* Identify all ways a quarantined staff member could do any level of non-client-contact work. Look beyond the duties of that person’s regular tasks; take advantage of their time to
	+ Schedule appointments
	+ Schedule and perform telehealth appointments
	+ Take educational courses and then share learned information with co-workers
	+ Provide or plan orientation and/or required training for
		- new staff
		- cross-training current employees
		- relevant staff on new regulations and requirements
	+ Stay up-to-date on new research, guidelines, etc. related to COVID
	+ Review and update policies and procedures
	+ Follow-up on any outstanding business related to insurance, billing, supplies and deliveries, etc.

**C: Planning**

* Create and post an outline of who will handle what, internally, ahead of time so there is no confusion if/when a key staff member is unable to work.
* Develop strategies to maximize use of telehealth:
	+ Learn what is and is not reimbursable
	+ Request that primary providers write orders for clients to specify inclusion orf telehealth visits in the orders
	+ Determine boundaries and limits of using telehealth without reimbursement for the good of the client when in-person visits are extremely difficult or impossible. It may be worthwhile to go without payment to maintain continuity of care and avoid discharges.
* Examine frequencies of services to see if some schedules could absorb changes, and for each client, create a grid to outline all services, and rank level of consequences. Cancel or postpone all non-essential visits. For example:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client  | Function*What task is being done and by whom?* | Impact Loss* *Marginal*
* *Critical*
* *Catastrophic*
 | Max Downtime*What is the maximum time between services before dangerous?* | Ideas for adjustment? |
| Tom Jones | Med set-up by nurse | Critical  | Could be set up monthly. Could only go 24 hrs without meds before dangerous. | Could family member do with telehealth supervision? |
|  | Shower/hair wash by aide | Marginal | Currently 2/wk; could easily transition to 1/wk. Dangerous if 2 wks pass w/o shower. | Add to another appointment to limit in-person client visits? |
|  | Therapy r/t hip replacement by PT | Critical | Currently 3/wk in person. Could do 1/wk in person + 2/wk telehealth. Significant set-back to client if less than 1/wk. | Based on client’s ability, move to maximal telehealth visits. |
|  |  |  |  |  |

* For each client, create and laminate instructional card(s) with specifics about services received. Post in client home so that anyone coming in to temporarily fulfill services would have individualized information to do the job.
* If staffing shortages are arising out of non-medical needs, for example staying home to care for children not in school, or due to lack of available in-home partner or closure of daycare; explore creative methods to help meet those needs to allow staff more availability for work.
	+ MN healthcare students are volunteering to help healthcare workers. To explore for availability in your area: <https://www.mncovidsitters.org/>
	+ A similar national group of health care students volunteering: [https://nsrnhealth.org/#](https://nsrnhealth.org/)
	+ Explore the feasibility of your staff assisting one another with childcare; perhaps offering to pay wages if one staff member at home cares for the children of at least two other staff members, freeing them to work.
* Watch trends and bed availability numbers affecting healthcare options in your county through MNTrac. This data will help you understand the situation which impacts your census. <https://www.health.state.mn.us/communities/ep/coalitions/mntrac.html>
* Identify online and local mental health resources to help with monitoring and treating stress and burnout.
	+ AMA: Creating a Resilient Organization Guide <https://www.ama-assn.org/system/files/2020-04/caring-for-health-care-workers-covid-19.pdf>

**D. Relationship Building**

* Set up a contract with an agency for relief staffing, including travel nursing agencies, even though
	+ They may not be able to help – they have shortages, too
	+ They may not have the right staff mix to meet your needs at any given time

If you need outside help, you don’t want to have to wait to identify and contract with an agency. Better to have the contract in place and not need it, than to not have anything pre-arranged and then have to scramble!

* Have a discussion with your local public health office to learn the extent of their abilities to offer support and help. <https://www.health.state.mn.us/communities/practice/connect/findlph.html#lhd>
* Learn who your Regional Healthcare Preparedness Coordinator is, and familiarize yourself with their resources. Be sure to be on their email distribution list for announcements of changes and/or increased offerings. <https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html>
* If your agency is part of a larger entity, have clear discussions about expectations, responsibilities, and reactions to urgent staffing situations. Know ahead of time what you can count on them to do for you, and check back frequently to see what’s changing. Make connections with the people you may need to talk to for staffing issues so you don’t have to spend time later figuring out who that is.
* If there are educational institutions in your area, consider exploring short-term use of health care students to meet service needs as appropriate and possible.
* Identify regional options clients could potentially be transferred to if your agency is no longer able to provide services. Establish connections with each to ease the process should it become necessary.
* Connect with local emergency services so that if the need should arise to enlist their help, you already know who to call.
* Consider entering into a compact with nearby agencies (see attached sample) to pre-arrange cooperation among neighboring agencies prior to need. Not a legally-binding document, a compact simply creates connections which can then be called upon in times of urgent need.

**E: State and Federal Resources** *(note: MDH resources aimed at congregate care settings have been reviewed, and tips relevant to home care and hospice have already been incorporated in the above sections)*

* State testing resources – knowing what testing availability will work for your staff can help minimize wait time for results, which keeps your staff from working.
	+ Information on testing: <https://www.health.state.mn.us/diseases/coronavirus/symptoms.html>
	+ Statewide testing locations (including info on free at-home testing by mail): <https://www.health.state.mn.us/diseases/coronavirus/testsites/index.html>
* Testing questions can be directed to MDH:
	+ Testing recommendations: COVID19@state.mn.us
	+ Testing support requests: covid.testing@state.mn.us
	+ COVID-19 case management: LTC.COVID19.MDH@state.mn.us
	+ Health care worker monitoring: CC.Monitoring@state.mn.us
* CDC Mitigating Staff Shortages <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>
* CDC Return-to-work guidelines <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>
* COVID Staffing Project (Vanderbilt University) includes staffing needs projection, PPE calculator, and more <https://www.covidstaffing.org/>

**If you have questions, corrections, or suggested additions to this document, please contact MHCA by emailing Karen Peterson,** **kpeterson@mnhomecare.org**

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HOME CARE AND HOSPICE COMPACT

This Compact is made and entered into by and between home care and hospice agencies located in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ area.

This compact is not a legally binding contract but rather signifies the belief and commitment of the home care and hospice agencies that in the event of a disaster, the medical needs of the home care and hospice clients will be best met if the agencies cooperate with each other and coordinate their response efforts.

Guidelines for participation in this Home Care and Hospice Compact:

* Meet at least twice annually to discuss emergency response issues and coordination of response efforts.
* Annually review existing plans and documents involving the home care and hospice agencies. This may include but is not limited to the home care and hospice compact response plans and memorandums of understanding.
* In the event of a disaster, home care and hospice agencies may contact other partners within the compact via the Regional Healthcare Resource Center (RHRC) or direct communication with peers.
* In the event that needed supplies are in surplus at one of the home care and hospice agencies and lacking at another, the home care and hospice agency with the surplus may share supplies to help ensure that clients in the stated area receive necessary care during the disaster.

Participation in the home care and hospice compact is voluntary and may be terminated at any time.

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