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April 24, 2020

To: All Long-Term Care and Assisted Housing Facilities
Re: Emergency Crisis staffing Guidance

I. Staffing:

In an effort to assist facilities and provide clarity regarding staffing expectations during this crisis, we are providing the following guidance.

All Long-term Care facilities (LTCF), including Assisted Housing facilities, should have emergency plans that include procedures and processes to address emergency a staffing crisis (for nursing homes, this is a CMS requirement for under the CMS State Operations Manual Appendix Z). Facilities should utilize mitigation strategies such as the cohorting of residents who are COVID-19 positive on one unit and using dedicated staff for that unit. This would reduce staff cross contamination to other units. Facilities should also develop contacts with other regional LTCFs who may have bed capacity and may be able to temporarily house and care for residents.

Emergency Staffing Plans--Progressive Steps

- Reinforce the hiring arrangements facilities already have in place (networking, use of social media, staffing agencies, etc.) and consider adding incentives to attract new employees/contracted staff during the emergency.
    - Prepare advertisements for vacancies in advance of the emergency, so time is not spent during the emergency drafting and approving such documents.
    - Those prepared-in-advance advertisements could also be written in such a way as to appeal to former healthcare workers (retired, out of work, or furloughed) who could be trained quickly.
- Network with other administrators and provider associations. This could include developing uniform disaster/crisis Memorandums of Understanding (MOU) and/or mutual aid agreements. These would allow a facility in crisis to get help from the other facilities that have signed the MOU.
- Contact your facility's corporate office or parent organization and map out plans for how and when to request staffing assistance from them. A parent organization should be able to send 1-2 staff from each of multiple facilities to provide support to the facility in need, without a negative impact to the sending facilities.
- Maintain a list of local health and other applicable facilities, municipalities, and/or businesses that might, during an emergency, furlough some or all of their staff. Develop contacts with those

organizations to create pathways that might both staff facilities in crisis, and keep those experienced individuals employed in health care.

- Work with the DHHS Commissioner's Office liaison for guidance, as well as assistance in identifying other sources of staff.
- Consider emergency/disaster staffing after due diligence hiring as described above is unsuccessful

Emergency Staffing Plans after implementing all Progressive Steps listed above:

This current COVID-19 crisis is fluid and Licensed facilities need to have reasonable documentation to demonstrate that they are doing due diligence to obtain and maintain facility staffing. Facilities that were unsuccessful in hiring and that have documentation of due diligence to obtain qualified (licensed and certified) staff) and are unable to do so, may then proceed with alternate/emergency crisis staffing. We provide the following as guidance for such a process.

The current nursing home Rules require that facilities have sufficient staff to provide the necessary care and services. (see 8.B.1 below). The Rules also allow for the use utilization of non-nursing staff to meet the needs of residents and the facility. The Rules allow for these non-nursing staff to provide resident care, when staffing patterns warrant a demonstrated need, and when the training, qualifications, and job descriptions reflect the activities/work these non-nurse staff are being hired to do. (see 8.C.2 below).

Thus, if in the case that a facility has insufficient C.N.A staff during the current crisis, a facility can create a COVID-19 staffing policy under 8.A, and determine the training and qualifications needed to fulfill the critical vacancies during this crisis. Once the staffing policy is accomplished a facility should modify or create job descriptions that address the tasks/duties identified and work expectations of these critical positions, and the training and qualifications needed.

For example, a therapist aide's job description could have an addendum attached to his/her job description outlining new tasks/duties during the crisis (assisting with resident transfers, ambulation, etc.). The same addendum would outline the minimum competency determination or training used to ensure the aide is competent to perform the new tasks/duties he/she is being asked to do during the crisis.

Once the staffing policy and the job description addendum are finished, and the facility has determined the therapist's aide is competent in performing the new duties, the aide e may perform those new tasks /duties. No waiver of any federal regulation or State rule is required.

8.A. **Personnel Policies**

The facility shall have policies that address all personnel practices.

8.B. **Staff Qualifications**

8.B.1. The facility must employ, on a full time, part time, or consultant basis those persons necessary to carry out the provisions of these regulations.

8.B.2. Staff must be licensed, certified, or registered in accordance with applicable State laws.

8.C. **Employees**

8.C.2. **Non-Nursing Personnel**

There shall be adequate numbers of non-nursing personnel to perform the necessary services and meet the needs of the residents and the facility. These persons shall not give resident care, unless staffing patterns, training, qualifications and job descriptions reflect the activities of such multi-purpose personnel.

II. Extreme Options:
If staff shortages continue despite all mitigation strategies noted previously, and despite the facility having implemented resident transfers consistent with CMS guidance QSO-20-25-NH, then prior to initiating any imminent closure activities, facilities shall contact the Maine CDC to discuss whether use of one of the following extreme options should be considered.

Options:

1. Staff who have had an unprotected exposure to a COVID-19 case, but who are asymptomatic and either have not been tested for COVID-19 or are COVID-19 negative may continue to work.

   In this option, staff need to comply with the following:
   a. still report temperature and absence of symptoms each day before starting work;
   b. wear a facemask (for source control; not a cloth face covering) while at work for 14 days after exposure to a COVID-19 case; and
   c. cease patient care activities and notify their supervisor if they develop even mild symptoms. If they develop symptoms, these individuals should be prioritized for testing.

2. Staff are well enough to work, but are COVID-19 positive, and have not met all Federal CDC Return-to-Work Criteria[1] may work, but only in a COVID-19 positive unit.

Only upon written approval by DLC and Maine CDC will option 2 be permitted.

Additionally, staff members described in Option 2 may only work where they would not increase exposure to residents and other staff (for example clerical and administrative duties without direct contact such as answering phones, coordinating outreach for staffing and supply needs, contacting families and physicians for communication and order clarifications, etc.).

Should COVID-19 positive staff work on a COVID-19 positive unit under this extreme option, they shall:
a. self-monitor for symptoms and seek re-evaluation if respiratory symptoms recur or worsen;

[1] Federal CDC Return-to-Work Criteria https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html.

b. wear a facemask for source control—not a cloth face covering-- at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer;
    i. After this time period, these staff should revert to their facility's policy regarding universal source control (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html) for the remainder of the pandemic.

c. be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) *and;*

d. their duties must be prioritized in the following order:
    1. perform job duties where they do not interact with others (e.g., patients or other staff), such as in telemedicine services;
    2. provide direct care only for patients who are confirmed COVID-19 positive, preferably in a cohort setting and through separate entrance and exits than those used by non-COVID-19 staff.

In addition to potentially exposing patients, these COVID-19 positive staff could also expose their co-workers. Therefore, these COVID-19 positive staff:

i. need to wear facemasks (not a cloth face covering) even when they are in non-patient care areas such as breakrooms;
ii. shall not use the same breakrooms as non-positive staff; And
iii. if they must remove their facemask (for example, in order to eat or drink), they should separate themselves from others and remain in the COVID-19 positive facility areas, before removing their facemask

Please monitor the CDC guidance ***at least daily*** as this continues to unfold.

Finally, in addition to visitor restrictions as outlined in the CDC guidelines, facilities are keeping residents in the facility unless they must go out for an essential appointment as outlined in the Governor's Stay Healthy at Home order.

Please feel free to contact or our office if there are questions regarding this notice.

Sincerely,

Bill Montejo, RN
Director, Division of Licensing & Certification

Cc: Dr. Siiri Bennett, MD, Maine CDC