Processes for Utilizing COVID-19 Positive or Suspected Asymptomatic Staff When a Facility is Experiencing an Outbreak and a Staffing Crisis[1]
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A staffing shortage or the need for crisis staffing are defined as when there are *no longer enough available staff to provide safe patient care.* This guidance is based on the Centers for Disease Control Strategies to Mitigate Healthcare Personnel Shortages.[2]

Facilities must receive approval from Aging and Long-Term Services (ALTSD) to implement crisis staffing. ALTSD staff will inquire about staffing on each call from an outbreak rapid response and throughout the outbreak, with approval for crisis staffing determined on a "case-by-case" basis.

Nursing homes are required to maintain adequate staffing levels pursuant to NMAC 7.9.2.50; 7.9.2.51; and 7.8.2.19. The obligation to maintain appropriate staffing lines is the responsibility of the facility. Facilities should also have a contingency contractor available for staffing purposes should the facility experience an outbreak and require additional staffing.

NOTE: A memorandum (page 17 of the PDF) was issued on September 11, 2020 from the Department of Health's Division of Health Improvement directing facilities not to allow sick or symptomatic staff to work. Facilities will not be cited that follow all guidance and receive approval pursuant to this memorandum.

The facility must be experiencing a current outbreak and a staffing shortage and have completed the following measures to attempt to augment staff:

- ✓ Contacted related facilities or partners including sister facilities and hospital partners;
- ✓ Contacted supplemental nurse staffing agencies;
- ✓ Contacted other nearby health care facilities, partners, or local university/college health career centers;
- ✓ Contacted trade associations to assist in obtaining staff;
- ✓ Activated its contingency staffing plan and has exhausted all options to address staffing needs, triggering a crisis level of staffing;
- ✓ Exhausted all options to cohort COVID-19-positive residents internally or transfer positive residents to COVID-19 care sites; and

[1] This guidance was compiled by the New Mexico Department of Health, The Aging and Long-Term Services Department with consultation, direction, and review by the Long-Term Care Medical Advisory Team. Multiple states were surveyed and found to have implemented similar if not identical guidance including but not limited to: Minnesota, Illinois, Wisconsin, New York, and New Hampshire. See https://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus/long-term-care-guidance, https://www.dhs.wisconsin.gov/covid-19/nursing-homes.htm, https://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html, https://www.nh.gov/covid19/resources-guidance/long-term-care.htm

[2] See https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

- ✓ The only remaining approach to ensure adequate resident care and safety would be to evacuate the facility.

Upon approval to implement crisis staffing procedures, the following processes must be followed:

1. Asymptomatic COVID-19 positive or suspected staff:
   a. Should take on a non-direct patient care role (e.g., telemedicine, phone triage), when feasible.
   b. Should monitor themselves closely for any new symptoms associated with COVID-19 (e.g., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or loss of taste or smell), and measure their temperature daily before going to work.
   c. Should remain at home and notify their supervisor if they develop any symptoms or have a measured body temperature of ≥100°f.
   d. If at work when fever or any symptoms develop, staff should immediately notify their supervisor and go home.
   e. Should provide direct care only for residents with confirmed COVID-19, preferably in a cohort/COVID-19 unit setting.
   f. Should practice diligent hand hygiene and wear a face shield and surgical face mask for source control at all times, including in non-resident care areas, such as breakrooms. A facemask for source control does not replace the need to wear an N95 or equivalent (or other PPE) when indicated.
   g. Should separate themselves from others if they need to remove their face mask.
   h. Should not work in facilities that are not currently experiencing an outbreak.

2. Facilities providing care for COVID-19 positive residents or patients using COVID-19 positive or suspected staff:
   a. Must know and document if the COVID-19 positive or suspected staff work in multiple locations.
   b. Must have a protocol for approval/notification/communication regarding staff who work in other long-term care facilities.*
   c. Must document the shifts worked by COVID-19 positive or suspected staff and the residents who received direct care from these staff members.
   d. Must ensure staff wear a face shield and surgical face mask at all times and receive training in proper use.
   e. Must actively screen all staff for symptoms and excluded from work if symptoms develop.
   f. Must restrict interaction between COVID-19-positive staff and other staff to prevent transmission via designated separate break area, entrance, bathrooms, and other communal areas for COVID-19 positive staff.
   g. Must continue to explore all avenues to obtain emergency staffing.
   h. Must not allow staff with confirmed COVID-19 to work after the facility is no longer in a staffing crisis.

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Facilities may also allow staff who are asymptomatic and tested negative but have had an exposure to continue to work and follow this guidance:

i. These staff should still report temperature and absence of symptoms each day before starting work.
j. These staff should wear a facemask (for source control) while at work for 14 days (this is the time period during which exposed staff might develop symptoms, i.e., the current incubation period for the virus) after the exposure event. A facemask instead of a cloth face covering should be used by these staff for source control during this time period while in the facility. After this time period, these staff should revert to their facility policy regarding universal source control during the pandemic.
k. A facemask for source control does not replace the need to wear an N95 or equivalent or higher-level respirator (or other PPE) when indicated, including for the care of patients with suspected or confirmed COVID-19.
l. If testing is readily available, performing post-exposure testing during the 14-day post-exposure period can be considered to more quickly identify pre-symptomatic or asymptomatic staff who could contribute to SARS-CoV-2 transmission.
m. 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.

NOTE

- Facilities should inform patients and staff when the facility is operating under crisis standards, the changes in practice that should be expected, and actions that will be taken to protect them from exposure to SARS-CoV-2 if staff with suspected or confirmed COVID-19 are allowed to work.
- Staff should be reminded that in addition to potentially exposing patients, they could also expose their co-workers.
- Staff should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until the full Return to Work Criteria have been met.
- Facemasks should be worn even when they are in non-patient care areas such as breakrooms.
- If they must remove their facemask, for example, in order to eat or drink, they should separate themselves from others.

*This guidance does not apply to acute care hospitals.