TheAcademy

Leading Health System COVID-19 Response Series

Ensuring Workforce Readiness and Resilience During the COVID-19 Pandemic

Raquel Davis, Associate, Research & Advisory, The Academy
Brian Contos, Special Advisor, The Academy

This briefing synthesizes data from surveying Academy members, insights gleaned from Leading Health System (LHS) Townhalls, and COVID-19 resources provided by member organizations.

Workforce Needs Are Front-and-Center in Pandemic Response

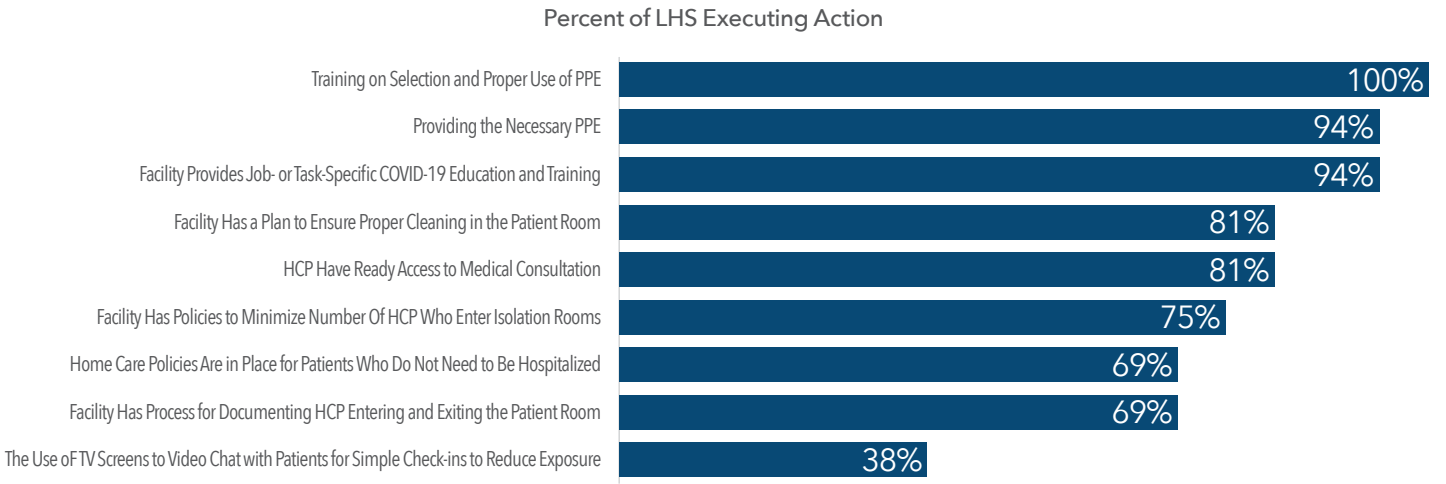
The workforce needs arising from the COVID-19 pandemic are numerous and urgent. The foundation of a strong, resilient workforce is safety, which has been tested under the strain of the outbreak. Workforce flexibility and agility are paramount at this time, and leaders must meet urgent staffing needs with smart redeployment while also addressing furlough and compensation challenges related to low census parts of the system. These efforts require a delicate balance of business and care team needs, effective communication, and support services for teams experiencing unprecedented levels of stress and uncertainty.

First Do No Harm: Protecting Staff from Infection

Ensuring Supply of PPE Persists as Significant Challenge

The possibility for significant reductions in available staff, including care teams and non-clinical personnel, due to COVID-19 exposure and/or illness from the disease, poses a considerable threat to LHS' ability to provide care to their communities. Accordingly, a top HR priority during the pandemic is to maintain the safety and resiliency of their workforce. Given their elevated risk of exposure, LHS have implemented a number of tactics to protect the front-line workforce. Not surprisingly, two of the top three actions being taken by LHS surround usage of personal protective equipment (PPE). As a baseline, these actions include training teams on the appropriate selection and use of PPE (100% of LHS) and providing the correct PPE based on the level of exposure risk (94%). Unfortunately, efforts to protect staff have been stymied by persistent supply shortages (e.g., N95 masks). Indeed, supply shortages present one of the greatest reported challenges for LHS (83% expressing concern) as they contend with the pandemic.

Actions Taken to Protect Heathcare Personnel (HCP)



While the extreme supply shortages experienced across March have become slightly less acute due to increased efforts at the local and federal levels to source and distribute supplies, coupled with greater production, LHS continue to have low inventories. To address shortages, several LHS have implemented creative solves, including fashioning their own PPE and adopting reuse protocols. For instance, Academy member Providence has created an initiative, the "100 Million Mask Challenge." Prior to local manufacturing companies stepping up in the region to increase production of masks and face shields, HCP began to make masks from supplies sourced at home improvement and craft stores. Providence has publicly released their templates for faces shields and surgical masks.[1] Several LHS have also instituted and shared reuse protocols.

[1] "100 Million Mask Challenge," Providence, accessed April 2020, https://www.providence.org/lp/100m-masks.

Innovative PPE Conservation Ideas

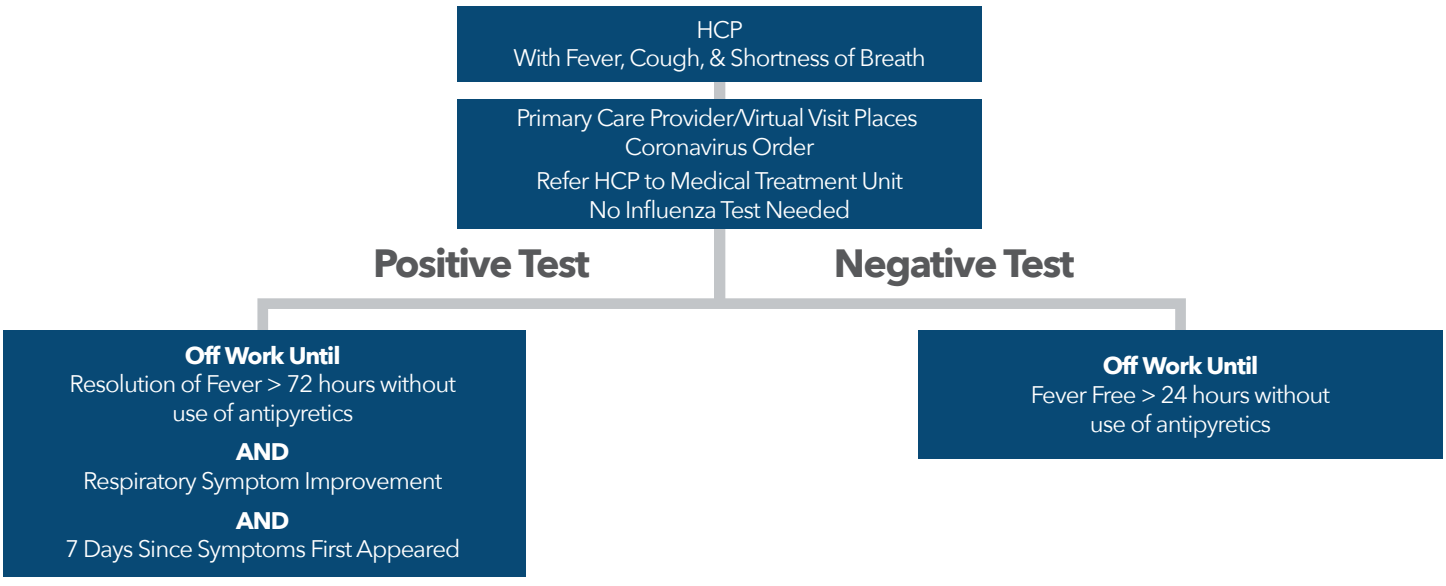
- **PPE for your PPE:** Some institutions adopting a three-layer protocol of N95 mask covered by a surgical mask behind a face shield; thus allowing longer use of N95 mask (USACS)
- **Vaporized hydrogen peroxide** as decontamination process, which allows multiple reuse of N95 masks (Duke[2])
- **UV radiation from lamps** or the sun being used to decontaminate masks (Nebraska Med[3], UMass, & USACS)
- **"Mask relay":** Some institutions rotating four masks and taking mask out of use for 96 hours to ensure no active virus contamination (USACS)
- **Fabricating face shields** from readily sourced materials leveraging staff- or volunteer-led assembly lines (Cox Health)

Handling Confirmed and Suspected Infections Is a Moving Target

Despite best efforts to reduce exposure risk, a large proportion of health system staff is likely to come into contact with or contract COVID-19. LHS have developed decision trees for managing these situations. Key considerations include triggers for quarantine and isolation and timing return to work. These considerations are under regular review given how quickly needs change as regions grapple with increasing case volume. For instance, as the pandemic began to escalate in early March, 37% of LHS had not implemented any employee quarantines. And for those that had, the guidelines often focused on travel-related exposure. Since then, responding to rapid increases in exposure (and multiple sources of domestic exposure), LHS have developed and implemented specific COVID-19 quarantine/isolation and return-to-work protocols dependent upon surge planning levels (e.g., conventional, contingency, or crisis modes), level of risk exposure (low, moderate, high, or very high), and staff test results (COVID positive or negative).

In creating these protocols, LHS are primarily following the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) guidelines. For instance, current CDC non-test-based strategy guidelines require HCP with confirmed or suspected COVID-19 to remain quarantined until three conditions are met, including resolution of fever for greater than 72 hours without the use of antipyretics, improvement in respiratory symptoms, and seven days having passed since symptoms first appeared. For unconfirmed cases, initially drafted protocols at some LHS required a 14-day quarantine, later shifting to seven days, and ultimately to no days if symptom free. This change in practice reflects that as the pandemic progressed and staff shortages increased, LHS moved to contingency and crisis mode surge levels, in which symptom-free staff who have had COVID-19 exposures are required to work (with appropriate PPE) to maintain necessary staffing levels.

CoxHealth's Criteria for Return to Work for HCP with Confirmed or Suspected COVID-19



Note: Accurate as of March 2020.

[2] Antony Schwartz et al., "Decontamination and Reuse of N95 Respirators with Hydrogen Peroxide Vapor…", Duke University, March 26, 2020, https://www.safety.duke.edu/sites/default/files/N-95_VHP-Decon-Re-Use.pdf.

[3] Gina Kolata, "As Coronavirus Looms, Mask Shortage Gives Rise to Promising Approach," The New York Times, last modified March 30, 2020, https://www.nytimes.com/2020/03/20/health/coronavirus-masks-reuse.html.

HR Finding Innovative Ways to Backfill and Redeploy Staff

In the early weeks of the pandemic, LHS had only begun to quantify the extent of, and contingency plan around, anticipated staff shortages. Shortly thereafter, data began to emerge around the virus's hit rate and high rate of asymptomatic transmission, and providers in hot spots shared their experiences with staff shortages. As of April, virtually all LHS are concerned with staffing levels and contingency planning as they account for recent surge models indicating the potential for severe shortages. McKinsey and Company has predicted up to a 20% loss in nursing staff nationwide due to nurses contracting COVID-19 or call-outs related to caregiver or childcare needs, immunocompromised status, and other factors.[4] Coupled with physician shortages (particularly critical care and pulmonology) and a diminishing supply of respiratory therapists, LHS have identified care team staffing as a major risk to their COVID-19 response efforts. To contend with impending staff shortages, LHS executives are deploying numerous innovative tactics, big and small. These strategies generally map to three categories: reducing strain on existing resources, addressing surge clinical needs, and redeploying staff to new support roles.

> *"We need enough rooms and technology, but if your health system doesn't have the required workforce, then rooms and technology are of little use. If 40% of staff become ill, your health system needs to figure out how to do things differently, because it will not be business as usual."*
>
> *– Chief Nursing Executive, Leading Health System*

Innovative Strategies Taken to Address Staffing Shortages

Reducing Strain on Existing Resources

- Cancel elective cases, other nonessential services
- Close hospital entrances
- Use AI, chat bots to triage low-risk patients
- Shift non-clinical tasks from clinicians to other staff and volunteers

Addressing Surge Clinical Needs

- Deploy anesthesiologists in ICU to provide intensivist care
- Call on retired clinicians
- Deploy senior medical and surgical residents, senior students in respiratory therapy
- Collaborate within and beyond hospital system to share workforce in higher/lower effected geographic areas and/or transfer patients
- Secure care team volunteers from other parts of the health care delivery system
- Deploy rapid re-training for clinicians new to ICU environment, vent management
- Develop tracking document mapping staff to key skills needed to facilitate quick redeployment

Resource Spotlight: Society of Critical Care Medicine's "Critical Care for the Non-ICU Clinician" [5]

Society of Critical Care Medicine
The Intensive Care Professionals

- Provides free online education to HCP who may benefit from critical care training
- Clinical tutorials include "Recognition and Assessment of the Seriously Ill Patient," "Airway Management," and "Mechanical Ventilation"
- Disaster Preparedness and Response tutorials include "ICU Microcosm Within Disaster Medical Response", "Augmenting Critical Care Capacity During a Disaster," and "Sustained Mechanical Ventilation Outside Traditional ICUs"

Partnership Spotlight: The Academy Partners with Merck, Pfizer, and Eli Lilly, Enabling Employees with Clinical Backgrounds to Volunteer Services to Local Health Systems [6]

MERCK Pfizer Lilly

- Announced medical service volunteer programs to enable employees who are licensed medical professionals to assist in fighting the pandemic while maintaining their base pay
- Together, these three major biopharmaceutical companies employ thousands of doctors, nurses, pharmacists, medical laboratory technicians, and other medical professionals

[4] "COVID 19 Crisis: US Healthcare Provider and Payer Preparedness," McKinsey & Company, March 17, 2020.

[5] "Critical Care for the Non-ICU Clinician," Society of Critical Care Medicine, accessed April 2020, http://covid19.sccm.org/nonicu.htm.

[6] "Medical Professionals Across Merck & Co., Inc., Pfizer Inc., and Eli Lilly and Company Activate to Support Health Systems…", Business Wire, April 1, 2020, https://www.businesswire.com/news/home/20200401005708/en/Medical-Professionals-Merck-Pfizer-Eli-Lilly-Company.

Redeploying Staff from Low-census Areas to New Support Roles

- Mobile testing/fever clinic personnel
- Off-site respiratory clinic personnel
- Donning/doffing spotters to ensure protocol compliance, staff safety
- PPE inventory controller
- Visitor greeter/screener to ensure strict adherence to policies
- Childcare personnel

Health System Spotlight: Sharp HealthCare Redeploys Staff to PPE Inventory Controller Role

- Moved all PPE, except for urgent care supplies, to a central location in the building with limited key access
- Assigned an AM and PM PPE Inventory Specialist to monitor supplies
- AM Inventory Specialist:
  - » Completes a morning count and logs prior to start of day
  - » Signs out/logs items being given throughout the day
- PM Inventory Specialist:
  - » Collects all open items and logs them back into the room at end of day
  - » Completes another full count and logs

Refusal to Work Cases Require Special Handling

During the COVID-19 crisis, LHS have seen an influx of employees claiming an inability to work due to underlying medical conditions (e.g., heart disease, lung disease, weakened immune system). Some LHS have adopted a COVID-19 work exemption process that is similar to their existing protocol for the flu. In one case, a health system created a committee of three physicians (one being a redeployed surgeon from a low census area) to review employee requests. Health system executives caution that if an employee is deemed eligible to work, but refuses to do so, disciplining or terminating the employee should be approached with caution given employee protections under the OSHA Act of 1970. In many cases, allowing the employee to use their PTO and unpaid medical leave is the more prudent approach. However, even if the employee's refusal is deemed justifiable, the Act does not require that the employee be paid for any time he/she is not at work due to refusal. Further, LHS have reported requiring employees refusing to accept redeployment assignments to take PTO until exhausted (and in some cases not permitting negative PTO balance).

Staff Deployment, Compensation Require Situation-Specific Analysis

LHS Currently Attempting to Avert Furloughs and Terminations

The COVID-19 pandemic has abruptly and dramatically changed LHS economics and staffing needs. On one hand, the pandemic requires significant increases in clinical team capacity given the growing demand for acute care. On the other, the cancellation of elective cases to conserve resources (supplies and clinician capacity) and reduce infection risk–and the resulting revenue loss–require careful review of employment needs and compensation. As a result, LHS must contend with numerous, difficult decisions surrounding staff deployment, furlough, pay and benefits. Similar to quarantine/isolation protocols, LHS have created scenario-dependent deployment/redeployment and pay policies.

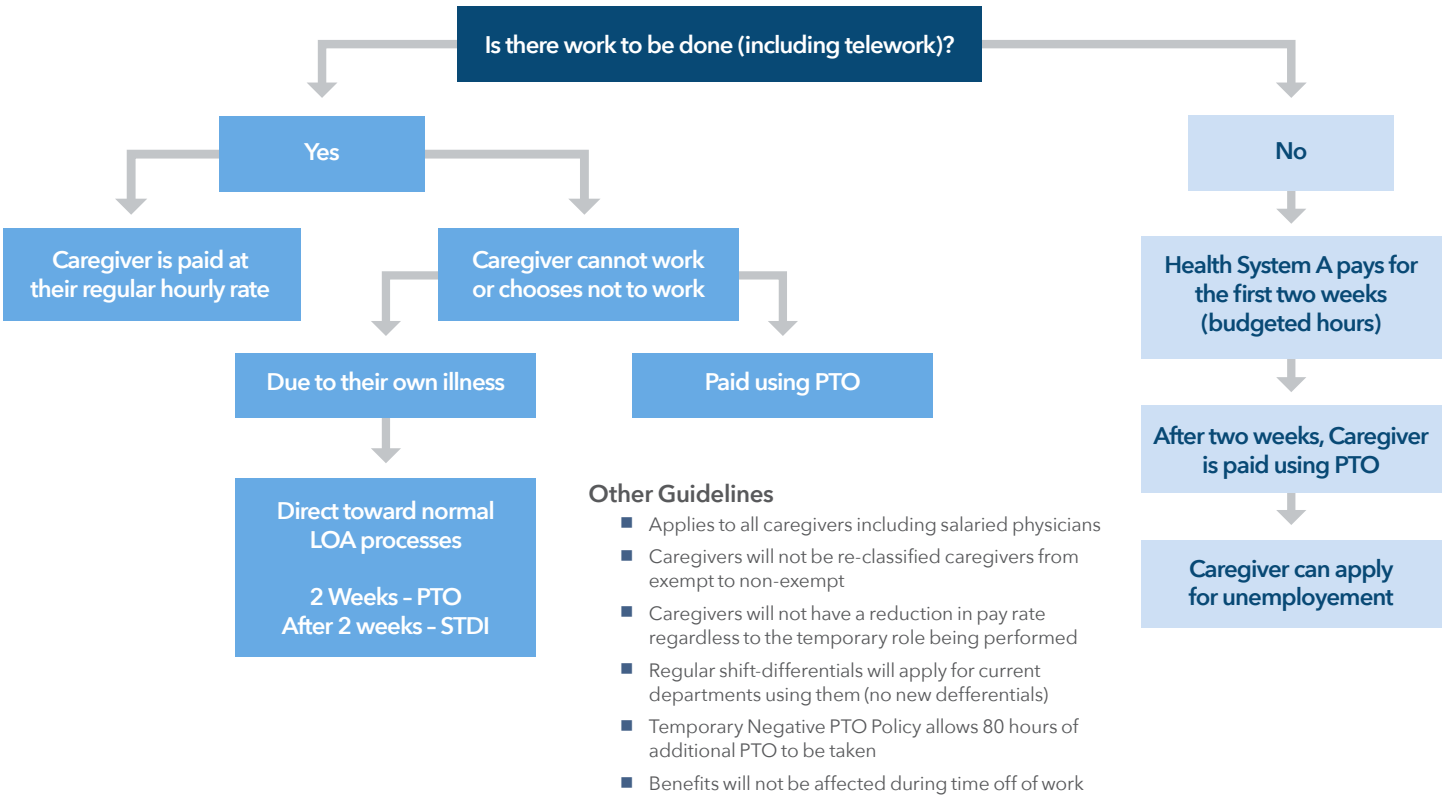
Attempting a Delicate Balance

- Protect their staff from economic hardship
- Retain workforce for uncertain surge scenarios
- Thwart poaching of staff by other systems
- Protect market share (should physicians leave)
- Avoid negative press associated with pay cuts, layoffs

Factors Impacting Decisions

- Exposure
  - » Work exposure: patient or infected team member
  - » Exposure due to travel to restricted areas
- Low census
  - » Mandatory site/department closures
  - » Redeployment to another area or role
- Surge needs
  - » Conscripting clinicians to hot-spot areas
- Personal care needs
  - » Short-term (non-COVID) personal illness or care of a family member (for COVID-19)

Health System A's Redeployment and Pay Protocol



A principal objective among LHS is to avert furloughs and terminations. In doing so, they are developing a number of tactics, which range from relatively easy solves to more drastic measures. By early April, decisions largely focused on buffering income loss for furloughed staff by permitting use of PTO days, adding days to PTO banks, or allowing staff to go into arrears on their PTO. For physicians in particular, standing up telehealth has been an important tactic for shoring up clinical care revenue (and therefore compensation for physicians). While an option of last resort, salary cuts and terminations are real possibilities.

Variety of Approaches Explored to Avert Furloughs and Terminations

Approach Severity

- Standing up/expanding telehealth to get physicians on platform to stem revenue loss
- Boosting PTO banks by 80 hours
- Permitting 80 hours of PTO in arrears
- Work share options in place of furlough or termination
- Staff sharing across system or state between surge/non-surge areas
- Letting reduced RVUs "flow through" to physicians (leading to lower compensation)
- Medical staff leave without pay then "double pay" when redeployed
- Physician pay cuts
- Executive pay cuts
- Permanent workforce reductions with anticipated long-term transformation in care delivery

Planning to Reduce Compensation for Low Volume Physicians

Health System in the West

- Redeployed staff will receive normal compensation
- Furloughed staff can use accrued PTO, may go into negative PTO balance up to 80 hours
- Some clinicians on RVU-based compensation experiencing significant reductions in clinical work
- Plan to temporarily reduce compensation for some low-volume physicians

Large Medical Group

- Planning significant compensation, benefits reductions to avoid layoffs
- Will suspend paid time off, matching contributions to 401(k), and discretionary bonuses
- Hours to be reduced for some to the minimum required to maintain health insurance coverage
- Administrative workers' pay to be cut 20% and executive pay cut 25%

"Hazard Pay" Discussed But Not a Sure Thing

Like many aspects of LHS' COVID-19 strategies, pay practices are evolving daily. Recently, the possibility of providing hazard pay has been introduced to the dialogue. Health care professionals have expressed concerns about their high risk of COVID-19 exposure, especially with PPE shortages, and believe they should receive additional compensation in the form of hazard pay. For HR executives, hazard pay (or other forms of added compensation like bonuses) is a possible retention tool. The idea is borrowed from out-of-industry, and the US Department of Labor defines hazard pay as, "Additional pay for performing hazardous duty or work involving physical hardship. Work duty that causes extreme physical discomfort and distress which is not adequately alleviated by protective devices."[7] While acknowledging the risks associated with COVID-19, some LHS executives have expressed concerns with hazard pay, making the point that their organizations are not philosophically aligned with the idea. Underlying their hesitation is the notion that providing acute care is inherently higher risk as compared to other professions. Furthermore, LHS believe prioritizing safety, by ensuring access to PPE and adding other resources to support care teams, is their primary focus. For a subset of systems, executives may still embrace the concept of hazard pay, but they would reframe it, with careful consideration of eligibility (who, when, and how to qualify) and review by their legal teams.

Effective Communication and Support Services Help Staff Manage Crisis

Effective Communication Keeps Staff and Community Informed Without Overwhelming

Given the amount of information that must be conveyed quickly and the frequent need to update or change information, LHS executives report communication to staff as a top concern in the context of the COVID-19 pandemic (78% of LHS expressing concern). LHS have created a centralized communication strategy to triage, process, and package myriad information from stakeholders inside and outside their organizations. How to communicate, how often to communicate, and how to target information to the correct personnel within the organization are all key considerations. Here too, LHS have adjusted their practice to match the current phase of the pandemic. For instance, early into the pandemic, 50% of LHS reported communicating with the full staff daily, and 44% indicated communication every other day. For those who communicated on a non-daily basis, executives cited trying to limit overexposure and a sense of panic. However, as LHS have entered later stages of the pandemic, they have turned to daily (or sometimes more than daily) communication, given the speed of change to policies and procedures. Typical communication channels include staff emails, intranet portals, text messaging, and periodic live virtual meetings. LHS are also providing employee hotlines, email addresses, and virtual assistance technology (e.g., chat bots) for employees to ask questions or make suggestions.

Communication Plan Checklist [8]

- ❒ Identify key public health points of contact for communication
- ❒ Assign responsibility for communications with public health authorities (primary and backup)
- ❒ Assign responsibility for communicating with the public (clinical spokesperson and public relations spokesperson with backups)
- ❒ Identify methods of communicating with public and subjects to cover
- ❒ Develop plans and responsibilities for communicating with staff, volunteers, private medical staff
- ❒ Develop plans and responsibilities for communicating with patients and their family
- ❒ Assign responsibility for internal communication with staff regarding status and impact of pandemic in hospital (primary and backup)
- ❒ Ensure types of communication needs (e.g., staff or community) and methods of communication (e.g., intranet, PSAs, etc.) are appropriate for individuals with visual, hearing, or other disabilities, or limited English proficiency
- ❒ Create list of other healthcare entities including points of contact (e.g., other hospitals, SNFs, clinics) with which regular communication is required

Addressing Childcare Needs Helps Reduce Absenteeism and Fatigue

The sudden closure of schools and childcare sites has introduced a tremendous burden for many households, which struggle to balance work demands and family needs. For HCP, the childcare dilemma is exacerbated because a large share of staff are essential personnel and are required to be onsite for long hours. To ease anxiety and reduce outside burdens on staff, LHS have implemented tactics to support childcare, including collecting need and capacity data, creating shared document sign-ups for matching prospective caretakers and staff in need, launching Facebook pages for one-on-one staff connections, and even standing up on-premises daycares in learning or fitness centers. No two health system approaches to childcare are the same; the options vary widely based on resource availability.

[7] "Hazard Pay," US Department of Labor, accessed April 2020, https://www.dol.gov/general/topic/wages/hazardpay.

[8] "Hospital Pandemic Influenza Planning Checklist," Centers for Disease Control and Prevention, June 2007, https://www.cdc.gov/flu/pandemic-resources/pdf/hospitalchecklist.pdf.

LHS Approaches to Support Childcare Staffing Needs

Health System A Using Area School Districts and On-site Learning Centers	Health System B Hosting Daycare Camps On-site and with Community Partners	Health System C Providing Staff with a Daycare Subsidy	Health System D Taking a Multifaceted Approach
■ Area school districts that called off school are staying open for childcare with regular and extended hours and setting up a Google Doc for employees to input their needs ■ Health system also leveraging its own internal learning centers	■ Having daycare camps at licensed facilities, such as internal health system fitness centers, local YMCAs, private provider organizations, etc.	■ Providing staff $50/day up to $500/month through the end of April for childcare ■ Employees must demonstrate that they lost childcare (or elder care) ■ Offering this as a tax-free benefit	■ Sent survey to assess staff needs and identify capacity ■ Hospitals converting spaces for daycare ■ Partnering with local YMCAs ■ Created a Facebook group for one-on-one staff connections ■ Publicizing their connection with Care.com

Supporting Mental Health Needs Is Essential for a Resilient Workforce

The COVID-19 pandemic has been traumatic for health care personnel across all roles. Addressing low morale and burnout is especially important because these conditions present significant risks to maintaining a prepared and resilient workforce.

LHS have turned to a variety of traditional strategies to reduce employee anxiety and stress, including expanding employee assistance program services and telehealth access to mental health professionals. They have also tapped into other strategies such as assistance in securing childcare (as described earlier), providing hotel accommodations to allow safe distancing from elderly family members, and even military tactics designed to reduce fatigue and burnout.

Issues Contributing to Fatigue and Anxiety

- Unable to provide all the care patients need
- Unable to provide reassurance to patents (time constraints, lack of PPE)
- Witnessing patients die without loved ones at bedside
- Physical exhaustion from long shifts
- Constant threat of becoming sick themselves
- Resource constraints across the board (tools for job, PPE, medical equipment, etc.)
- Lack of adequate support outside of work (e.g., childcare)

"Our health system created a workforce protection and sustainment team. This team is led by staff with military backgrounds, and strategies are being used from the military (e.g., tactical napping, identifying signs of coworker fatigue). This pandemic is a marathon, not a sprint."

– Vice President of Human Resources, Leading Health System

Guidance for LHS on Workforce Wellbeing During COVID-19

Stress

- Establish protocols to monitor workforce health in the context of COVID-19
- Offer proactive mental health support
- Provide support for caregiving

On-the-job Support

- Sleep
  - » Use nearby hotel capacity
  - » Use collegiate residence halls emptied due to school closures
- Food
  - » Partner with local restaurants to set up food delivery

In-house Support

- Provide online resources on working remotely
- Provide virtual video equipment for employee engagement
- Create at-home caregiving flexibility
- Leverage community support for childcare and grocery pick-up

The Power of a Phone Call

"Our health system has committed to calling all 10,000 employees across two weeks. It's an idea we got from a utility company that did this after a major hurricane. It's been incredibly valuable for getting feedback, reassuring our team, and identifying problem areas."

– CHRO, Leading Health System

For further, more in-depth strategies in caring for HCP during COVID-19, please visit the American Medical Association's website.

US Army Tactics for Coping with Deployment and Combat Stress [9]

Items Applicable to HCP During COVID-19

Examples of Individual Preventive Actions to Combat Stress:

- Focus on the mission
- Follow Standard Operating Procedures (SOPs)
- Focus on success
- Breathe deeply and relax
- Know Combat and Operational Stress Reactions (COSRs) are normal
- Keep open communication with your team
- Gather facts
- Drink plenty of fluids
- Eat well balanced meals
- Maintain personal hygiene
- Keep active and stay physically fit
- Sleep at least 7-8 hours in each 24 hours, if possible
- Debrief after unusually stressful events
- Know and practice self aid/battle buddy aid

How to Provide Battle Buddy Aid:

- Be a good friend
- Listen attentively
- Stay calm and objective
- Don't argue with the Soldier's thoughts and feelings
- Acknowledge the Soldier's grievances but don't amplify them
- Ask questions to help you understand
- Delay offering advice until your Soldier knows you really know the situation
- Plant the seeds of new ideas
- Praise the solider for the work he/she has been doing

Examples of Leader Preventive Actions to Combat Stress:

- Be decisive and assertive; demonstrate competence and fair leadership
- Preserve Soldier's welfare, safety, and health
- Be aware of environmental stressors
- Learn the signs of stress in yourself and others
- Recognize that fear is a normal part of combat stress
- Help Soldiers to address any family concerns and/or separation, economic problems
- Provide an upward, downward, and lateral flow of communication
- Create a spirit to win under stress
- Ensure training includes understanding of combat and operational stress and how to deal with it
- Look for stress signs and a decreased ability to tolerate stress

For further military strategies and tactics to combat stress, please visit the US Army and US Army Public Health Center's (USAPHC) "Guide to Coping with Deployment and Combat Stress."

Additional Resources

To stay current on COVID-19 information across the LHS market, the Academy encourages members to:

- Participate in upcoming **Academy Townhalls**
- Obtain protocols and guidelines from **The Academy's COVID-19 Resource Center**
- Contact The Academy's COVID-19 Task Force with your questions at **COVID19@hmacademy.com**

[9] "Guide to Coping with Deployment and Combat Stress," US Army and USAPHC, April 9, 2018, https://ephc.amedd.army.mil/HIPECatalog/Uploads/DownloadableProds/124_TG320.pdf.