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Breakout Session 2: Staffing Models

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Brief Report

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Abstract

During the "Alternate Care Facility (ACF) Symposium: Understanding National Experiences in Planning and Operations," over 4 dozen ACF subject matter experts were invited to discuss their experiences with planning, activating, and running ACFs. The staffing model session focused on participants' experience with selecting the most appropriate staffing model, staffing ratio, supervision structure, staff recruitment, and education and training. The group identified several successful models, just-in-time training, and proposed approaches to ensure effective staff allocation during crises.

Introduction

During the staffing models' breakout session, participants were encouraged to discuss their real-world experience regarding ACF staffing models, recruitment and retention, staff training and education, and influencing factors that impacted the optimal staffing of an ACF. The goal of the session was to collate and curate participants' lived experiences, rather than proposing solutions or models for potential scenarios. Participants explored their approaches to determining ideal staffing model, staffing ratio, supervision structure, training and education of staff, and flexibility of models to timely adapt to ACF staffing needs. The discussion covered challenges, particularly when dealing with nontraditional staff or supervision models, compensation ethics, and recruitment, as well as licensure and credentialing of staff. The group identified several successful models, just-in-time training, and proposed approaches to ensure effective staff allocation during crises.

Facilitators used the following questions to prompt participants and guide conversation:

- What did the staffing model at your ACF look like? Include specific examples
  - Who staffed the ACF (physicians, nurses, advanced practice providers, trainees, etc.)? What was the pre-determined staffing ratio?
  - Was staff relocated to your ACF from another unit? If so, which one? Did your ACF hire de-novo staff? What did their schedule look like?
- Describe some of the successes your ACF experienced with your staffing model
  - How were these sustained?
- Describe some of the challenges your ACF experienced with your staffing model
  - How were these addressed?
- Based on your experience, do you have any recommendations for ACF staffing models' best practices?

To encourage further detailed discussions, additional questions were available for facilitators to use as needed. These questions could be asked if group discussions slowed during the 50 minutes and if time allowed. Some groups discussed some of these questions while others did not have time.

- Were these staffing models based on any evidence or available guidelines?
  - Please provide specifics
- Based on your ACF's patient selection criteria, what clinical roles were essential to safely staff your ACF?
  - If any, which roles were expanded or adjusted to meet needs?
- What level of experience (e.g., novice vs expert vs. mix) was acceptable for your ACF care environment?
- What kind of onboarding or just-in-time training did staff need to feel prepared?
  - How was just-in-time training (or other training) delivered?
- What criteria/triggers led to increasing or decreasing staffing expertise level or ratios?
- Were there creative ways to address any staffing shortages?

Four overarching themes emerged during this prolific session.

Theme 1: What Was Done

- **Tiered Staffing Models and Skill Extenders.** Most participants described a tiered staffing model, in which Subject Matter Experts (SMEs), those experienced with the clinical care of

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acutely ill patients, in most cases internal and family medicine, critical care, or emergency medicine physicians, would supervise pods of providers with less differentiated expertise (advanced practice providers, house-staff, CRNAs). Implementing these models required regulatory flexibility to operate slightly outside of conventional scope. For example, Emergency Medical Technicians (EMTs) would administer non-IV medications under direct nursing oversight. Many participants identified personnel shortages as the key limiting ACF capacity factor.

- **Just-in-Time Training (JITT).** Although participants did not describe the selected pedagogic methodology, JITT was deemed essential for addressing immediate clinical (i.e., personal protective equipment, dynamic management guidelines, particularly for COVID-19, etc.) and operational gaps (i.e., Electronic Medical Records/paper charting). The development of timely JITT required substantial SME commitment to swiftly validate competencies, develop training materials, and provide optimal oversight, particularly for providers with limited acute care experience. The need for training and supervision was evident, particularly when new graduates who had "never seen a patient" in an acute setting were hired. Attention was given to the "right SME" for the "right event" whenever possible. Many participants highlighted the need to plan not only for the health care delivery staff (physicians, nurses, pharmacists, physical and respiratory therapy, etc.) but for administrative, food and nutritional services, and environmental services staff as well.
- **Operational Models and Sourcing Strategies.** Participants described the need to engage operational leaders to develop staffing strategies that relied on rapidly assembled, diverse personnel pools, often utilizing and adapting skills outside of traditional roles.

Theme 2: Success and Sustainment

- **Nonclinical Staff Integration.** Successful ACFs effectively integrated existing nonclinical facility staff (i.e., hotel engineers, housekeepers, security) into the operational structure, leveraging their mastery of the physical space. Some sites integrated the hotel's rooming software for patient tracking. In several discussion groups, participants who worked in hotel-based ACFs, which were mostly used for quarantining (COVID-19, measles, etc.), supported the incorporation of hotel staff, already familiar with facility, into ACF operations. However, they highlighted the need for those staff to abide by infection prevention regulations, hence undergo JITT. For cases in which personnel stayed during hotel-based ACF activation for measles quarantine, measles titers and vaccination status were tracked.

Theme 3: Challenges and Mitigation Efforts

- **Regulatory Hurdles.** Participants identified that significant time was diverted to securing temporary state licensure waivers for incoming clinicians. Participants representing an ACF in Maryland during the COVID-19 pandemic described how credentialing efforts were divided between 2 collaborating institutions: one took care of physician and APP credentialing, while the other focused on nursing and ancillary staff credentialing.
- **Ethical Cost of Staffing Disparity.** The reliance on high-cost emergency contracts created the ethical dilemma of "robbing Peter to pay Paul" by drawing staff away from local health care facilities with significantly lower pay, compromising broader regional health care capacity.
- **Unmitigated Interpersonal Conflict.** The high-stress environment exacerbated interpersonal conflicts, resulting in documented incidents of collateral nonphysical violence and friction, including arguments among multidisciplinary staff, that leaders were often ill-prepared to mediate. The lack of dedicated ACF embedded Human Resources (HR) support contributed to the challenges of dealing with interpersonal conflict.
- **Extreme Operational Flexibility.** While frontline responders thrive in uncertain environments, this operational flexibility, with frequently rotating staff, staff with disparate training, and dynamic care guidelines and protocols, inevitably led to the team members' perception of elevated risk and operational chaos.

Theme 4: Potential Future Directions

- **Establish Equitable Staff Deployment Incentives.** Participants proposed considering the implementation of regional agreements among health care systems that include equitable deployment incentives, beyond the clinical staff, during an emergency. This could help mitigate the ethical cost of staffing compensation disparities.
- **ACF Specific JITT.** Participants suggested developing an all-hazard JITT curricula that focuses specifically on ACF basic disaster operational protocols. A user-friendly, freely available, and vetted ACF curricula could help quickly enable the readiness of nontraditional staff.
- **Embedded Human Resources.** A plan to rapidly deploy and integrate HR and stress management personnel as an essential component of an ACF leadership team was proposed as crucial by session participants. And, if not affiliated with an institution, occupational health ought to be considered as well.

Summary

Staffing emerged as the most significant operational constraint in ACF activation and sustainment. Symposium participants reported that personnel shortages, and not physical bed space, were the key limiting factor in facility capacity. The timely recruitment and onboarding of a heterogeneous workforce introduced substantial operational challenges, including extreme wage disparities, interpersonal conflicts, and burnout. The ACF staffing success relied on tiered models, creative use of nontraditional personnel, and just-in-time training.

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