Emerging From the COVID Crisis With a Stronger Health Care Workforce
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Abstract
The COVID-19 pandemic has highlighted the limitations of the current health care workforce. As health care workers across the globe have been overwhelmed by the crisis, oversight entities and training programs have sought to loosen regulations to support ongoing care. Notably, however, workforce challenges preceded the current crisis. Now may be the time to address these underlying workforce challenges and emerge from the COVID-19 pandemic with a stronger health care workforce.

A crisis—including the COVID-19 pandemic—should never be wasted. The COVID-19 pandemic presents a disruptive challenge to the health care system, and the U.S. medical community should embrace the opportunity to transform the health care workforce to better meet the needs of society in the future. COVID-19 has overwhelmed health care workers in localities across the globe physically, emotionally, and ethically. Accreditors, health professions schools, postgraduate training programs, governmental entities, and health systems have all taken steps to rapidly bolster the capacity of the health care workforce.

Building upon historical exemplars in the context of the current crisis, the authors of this Perspective provide a roadmap to rapidly and safely increase the workforce for COVID-19 and beyond. The authors recommend the following: (1) a comprehensive approach to guide health care workforce development, (2) streamlining transitions to the next level of practice, (3) reciprocity among state licensing boards or national licensure, (4) payment reform to support a strengthened health care workforce, and (5) efforts by employers to ensure the ongoing safety and competence of the bolstered workforce. These steps require urgent collaboration among stakeholders commensurate with the acuity of the pandemic. Implemented together, these actions could address not only the novel challenges presented by COVID but also the underlying inadequacies of the health care workforce that must be remedied to create a healthier society.
education. Similarly, pharmacy schools have worked closely with state licensing boards and the national accreditation agency to enhance flexibility for clinical training.

While these efforts are important first steps, expanding the health care workforce to address both the COVID-19 crisis and the challenges that preceded it requires strategic coordination across health systems, licensing boards, accreditors, and entities (e.g., the Centers for Medicare and Medicaid Services [CMS]) that pay for training. Over the next several months, COVID-19 may flare heterogeneously, and the workforce needs to be adaptable. The ideal response must be interprofessional and longitudinal. Moreover, changes are necessary to ensure the adequacy of the workforce long term. In this Perspective, we briefly outline 5 recommendations that would address the underlying inequities in the current U.S. system and help prepare for future crises: (1) a comprehensive approach to guide health care workforce development, (2) streamlining transitions to the next level of practice, (3) reciprocity among state licensing boards or national licensure, (4) payment reform to support a strengthened health care workforce, and (5) efforts by employers to ensure the ongoing safety and competence of the bolstered workforce.

A Comprehensive Approach to Guide Health Care Workforce Development

The United States needs a comprehensive approach to guide the health care workforce. The National Health Care Workforce Commission, established by the Affordable Care Act but never funded by Congress, might serve as a model. The commission was created to study the workforce and advise the federal government on trends, anticipated changes, and future needs. Moreover, the role such a group could play in resolving disputes between entities involved in training and regulating the health care workforce would be as important as its role in guiding the development of the health care workforce. One example is the controversy around the varied scope of practice and inconsistent entry into practice among nurse practitioners and pharmacists practicing in different U.S. states. Also polemical are the conflicts of interest inherent in licensing entities that rely on income from test administration. A group such as the National Health Care Workforce Commission could work to resolve these disagreements in a way that most benefits the population.

Since such a federal entity does not exist, addressing COVID-19 requires urgent collaboration among nongovernmental groups that are involved in the transitions during training and into independent practice. Meanwhile, these efforts should also seek to solve long-term disparities in access to care and health outcomes. Collaboration might include organizations for each profession and across professions including but not limited to the following:

1. Associations involved in health professions training such as the Association of American Medical Colleges (AAMC), the ACGME, the American Association of Colleges of Pharmacy (The Council of Deans for each profession may represent the best neutral conveners for this work);

2. Entities devoted to health care delivery such as the American Medical Association, the American Nurses Association, the American Society of Health System Pharmacists, and the American Hospital Association;

3. Groups that provide accreditation and oversight such as the LCME, the Accreditation Council for Pharmacy Education, the ACGME, and the Commission on Collegiate Nursing Education;

4. Licensing agencies such as the Federation of State Medical Boards, the National Council of State Boards of Nursing, and individual state licensing boards;

5. Funders of both graduate health professions education and patient care such as CMS and state Medicaid offices;

6. Groups whose members have expertise in considering these issues, such as the Coalition for Physician Accountability, through which 12 physician organizations seek “to advance health care and promote professional accountability by improving the quality, efficiency, and continuity of the education, training, and assessment of physicians.”

Streamlining Transitions to the Next Level of Practice

Transitions from each level of training to the next should be streamlined. Educational programs, institutions sponsoring postlicensure training (e.g., residencies), and oversight entities need to implement processes that support trainees who have been designated as competent for the next level of independent practice. While competency-based programs have shown that many medical students can enter residency early, the rigidity of the fourth year of medical school remains a barrier. Overcoming this barrier requires collaboration among—and potentially some sacrifice of control and income by—multiple stakeholders including the LCME, the National Board of Medical Examiners, the National Resident Matching Program, the ACGME, schools of medicine, and even students. Recent changes to the United States Medical Licensing Examination Step 1 demonstrate the capacity for this type of collaboration, and the ACGME is working on new competency-based criteria for academic programs with the potential to move to time-variable clinical education. Augmenting the pharmacy workforce will entail closer coordination between PharmD degree programs and pharmacy residencies. All these efforts require coordination and leadership.

Reciprocity Among State Licensing Boards or National Licensure

A more nimble and effective health care workforce requires either reciprocity among state licensing boards or national licensure. During COVID-19 and in the aftermath of prior natural disasters, temporarily waiving state licensure has allowed health care providers to migrate to overwhelmed areas. Despite this demonstrated advantage, licensure remains primarily a state-by-state process. An exception is the Nurse Licensure Compact, enacted by 32 states, which allows reciprocity of licensing for nurses. Building on this model—and perhaps building toward national licensing—allows the flexibility to rapidly relocate health care providers where need surges (as in COVID-19 outbreaks). National licensure or reciprocity would also create opportunities for practitioners to partner with underserved
Call to Action
COVID-19 is a crisis that has already changed the approach to health professions training and care delivery in the United States. The challenge and resulting short-term adaptation represent an opportunity to address some of the long-standing inadequacies of the U.S. system. Given the complexity of its regulatory, reimbursement, and oversight systems, transforming the U.S. health care workforce is a Herculean task, and there are no easy paths forward. However, all of us are experiencing a time of unprecedented crisis, and now is the time to strengthen the health care workforce so we can emerge from COVID-19 stronger than ever.

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Payment Reform to Support a Strengthened Health Care Workforce
CMS, the U.S. Department of Veterans Affairs, state Medicaid entities, and other payers need to fund a strengthened and more agile health care workforce. COVID-19 has already led to adjustments in payment and more flexibility for telehealth. These changes were needed and should be formalized to address health inequities across the United States. In addition, transitioning to competency-based models may require more adaptable and increased support for GME, nursing education, and pharmacy education. As leaders define additional paths to a workforce better aligned with the needs of the population, payment must also change.

Efforts by Employers to Ensure the Ongoing Safety and Competence of the Bolstered Workforce
Health systems and other employers must ensure both the safety and competence of the bolstered workforce. As the workforce evolves, clinical leaders must not only be certain that standards of care are maintained but also be attentive to onboarding, orientation, entrustment, and supervision to ensure desired patient outcomes. Relatedly, clinical leaders must support the safe practice of new health care workers trained under time-variable systems by appropriately assigning job duties—similar to processes for initiating new medical trainees in July. For example, preferentially assigning new workers to non-critical care units and granting responsibility commensurate with experience helps workers provide safe, effective, high-quality care. Health care workers who undergo retraining or those who return from retirement to support the workforce during a crisis need similar support. Everyone, especially novice practitioners, needs safe working conditions including readily available personal protective equipment. Most importantly, system leaders must ensure adequate competency and standards of care, and they must provide feedback to training programs on deficiencies of recent graduates.
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