State Responses to Address Workforce Needs in the Initial Wave of the Pandemic

Background

The COVID-19 pandemic is having substantial impacts on the healthcare delivery system and the health workforce. In response to surging cases, states responded with a variety of approaches to ensure adequate health workforce capacity as well as strategies to expand access to care for needed services. In order to better understand pandemic issues and challenges faced by states as well as strategies they used to address them, a research team from the Health Workforce Technical Assistance Center (HWTAC) conducted 32 key informant interviews with stakeholders in 23 states during the first 6 months of the pandemic to learn more about their efforts. In addition, researchers from the Health Workforce Policy Research Center at George Washington University conducted an in-depth policy analysis of certain regulatory actions taken by states to support health workforce efficiency and flexibility in the delivery of health care services. This research brief summarizes early findings to date from both arms of this research. While no 2 states experienced the pandemic the same way, a number of recurring themes have emerged on how states prepared for and responded to the pandemic.

Regulatory Flexibility

States maintain broad authority to regulate their health workforce through several avenues, including statutes, executive orders, and agency regulations. While statutes and regulations have the advantage of being permanent, the process for developing them can be slow and iterative. Executive orders, on the other hand, can be quickly introduced and implemented, but expire after a certain time period. During the pandemic, states relied on executive orders to address pressing needs, including issues pertaining to the health workforce. Three areas of workforce regulation addressed in executive orders enacted in many states in response to COVID-19 had the potential to not only help address

the emergency needs of the pandemic but also to touch on long-standing topics of debate: scope of practice; licensing requirements for out-of-state health care professionals; and access to telehealth services.

Scope of Practice

State regulatory bodies and legislatures set scope of practice (SOP) requirements for health care professionals dictating the services they can provide and the conditions under which they can do so. Although professional organizations, especially those representing advanced practice clinicians like physician assistants (PAs) and advanced practice registered nurses (APRNs), have long advocated for their members to be able to practice at the top of their license, health professionals' ability to do so varies greatly by state.[1] In response to the pandemic, some states loosened SOP restrictions, not only for advanced practice clinicians, but also pharmacists, emergency medical technicians, and assistant-level health care staff. Emergency policies expanded SOP by waiving supervisory or collaborative practice agreement requirements or by expanding health professionals' practice authority, allowing them to perform additional specified services or to practice to the full extent of their education and training, sometimes referred to as 'full practice authority'.

Facilitating the Licensing of Out-of-state Health Care Professionals

Any health professional seeking to practice in a state must obtain a license recognized by that state. This often requires a formal application that includes documentation of passing licensure exams and paying an application fee. In the wake of COVID-19, many states modified licensing requirements to quickly build workforce capacity and promote ease of practice across state lines both in person and virtually through telehealth. Types of regulatory flexibilities addressed by executive order have included allowing inter-state license reciprocity if a professional's home state license

is in good standing or issuing expedited or emergency temporary licenses for out-of-state health professionals.

Enabling the Greater Use of Telehealth Services

The pandemic resulted in the rapid and widespread adoption of telehealth to expand access to care while avoiding exposure risks posed by in-person clinical visits. This shift was facilitated by both federal and state policies. In March 2020, the Centers for Medicare and Medicaid Services (CMS) issued temporary blanket waivers that increased flexibility for Medicare coverage of telehealth services for all states, including broadening the definition of eligible practitioners who could bill Medicare for their services and allowing audio-only modalities.

States also expanded access to telehealth through their authority to regulate Medicaid and the private insurance market. Since March 2020, nearly every state has enacted mandates or guidance expanding access to telehealth.[2] Emergency telehealth policies cover a wide range of provisions that are aimed at expanding: the types of providers that can be reimbursed; covered services and where the services can be provided (eg, home); and allowable telehealth modalities including audio-only. Additionally, some states instituted requirements or guidance for telehealth payment parity (ie, reimbursement at the same rate as in-person services). Some states have taken action to codify temporary telehealth policies into law through the legislative process,[3] ensuring that telehealth expansion will persist beyond the current emergency.

Building Surge Capacity for Acute Care Services

An immediate response to the pandemic was a rapid expansion of acute care beds as the number of cases surged. Efforts made by states to build surge capacity in acute care generally included:

- Recruitment of additional health workers from within and out-of-state

- Shifting existing staff within health systems to areas of greater need

- Utilizing existing staff in new roles

The most sought-after health professionals during the early stages of the pandemic were those with respiratory care and intensive care experience, including nurses, physicians, and respiratory therapists, among others. Temporary staffing agencies were overwhelmed during the initial stages of the pandemic due to demand by hospitals attempting to build surge capacity. This led to bidding wars for temporary staff that favored large health systems with more resources. A few states set up databases with information on licensed health professionals (eg, specialty, availability, etc.) to help hospitals recruit personnel to needed areas. These databases often included both inactive licensees and retirees in addition to active personnel. At the same time, large health systems shifted existing staff to sites that experienced a greater surge in acute care cases.

Impacts on Ambulatory Care Services

While many states struggled to build surge capacity in acute care, ambulatory services and elective procedures were paused in many locations around the country. Access to in-person primary care, specialty care, and oral health services were limited during the early stages of the pandemic. In addition to preventing the spread of the contagion, a key factor contributing to this 'pause' was lack of access to personal protective equipment (PPE) due to availability, cost, and the priority given to acute care providers. Some ambulatory health care workers were also initially furloughed in response to this pause, while others were redeployed to acute care settings. However, staffing redeployments were more common within large health systems than between different systems according to key informants. Some National Health Service Corp recipients were furloughed, disrupting fulfillment of required service. States reported working closely with the Health Resources and Services Administration to temporarily suspend obligations, where indicated, with a plan to resume the obligation when possible.

States reported a surge in the provision of telehealth services that occurred primarily in ambulatory care, with telehealth visits replacing in-office visits for primary care and specialty care services. Many states reported that behavioral health services saw the largest increases in telehealth usage and that it appeared to be very successful in engaging patients and retaining them in treatment. Some states attributed this, in part,

to the fact that there was much less stigma associated with telehealth visits compared to in-person visits to behavioral health service providers.

Impacts on the Health Professions Educational Pipeline

Many states reported that in March 2020, when cases began to surge, healthcare providers advised health professions education programs that students would not be allowed to complete scheduled clinical rotations, jeopardizing student graduations in the spring. This was true for both acute care and ambulatory service training sites and affected many health professions, particularly nursing and medicine. Residency training was also disrupted, affecting some specialties more than others. For example, the pause in elective surgeries limited the ability of surgical residents to fully meet clinical requirements. Access to testing sites for NCLEX licensing exams also diminished substantially and many newly graduated registered nurses (RNs) were unable to sit for the required licensing exam in a timely fashion. In response to this, states and in some cases accrediting agencies worked closely with education programs to assure on-time graduation and deployment to facilities needing workers. Among the state strategies:

- Allowing health professions students to volunteer at a health care facility for educational credit (in the absence of an affiliation agreement)

- Providing alternatives to clinical rotations (eg, simulation, off-shift clinical rotations), facilitating on-time graduation for students

- Extending the time that a newly-graduated RN or licensed practical nurse (LPN) could work on a limited permit while awaiting access to licensing exams and results

Many of the newly-graduated health professionals were deployed to work in facilities struggling to staff expanded acute care services.

Impacts on Vulnerable Populations

Several key informants remarked on the pandemic's uneven impact on residents of their states, ie, certain vulnerable populations experienced higher case rates and mortality. These populations included American Indians living on tribal lands; minorities; immigrants and refugees; meatpacking plant workers; and residents in nursing homes and assisted living communities. Rural areas also faced unique challenges since they often lacked resources needed to manage acutely ill patients.

Discussion

There were a number of themes that emerged from the key informant interviews and policy analysis on how states prepared for and responded to the pandemic. In states hit hard by the pandemic, governors used executive orders to immediately loosen regulatory restrictions in efforts to build workforce surge capacity. These executive orders waived or modified licensure requirements for out-of-state healthcare professionals; relaxed supervisory requirements and expanded practice authority for nurse practitioners and PAs, among others; and enabled greater use of telehealth services.

Looking ahead, it is important to monitor the pandemic's continued workforce impacts and the strategies used to address them. Emergency measures enacted by states should be evaluated for effectiveness. The strategies used to confront the pandemic may ultimately lead to permanent policy changes that create greater access to care, especially for the underserved. In addition, pandemic effects on the health professions education pipeline need to be closely examined to minimize disruptions and ensure the production of health professionals. The COVID-19 pandemic has had a devastating impact on the nation's health and healthcare system, and learning more about state responses and their effectiveness may inform preparations for future disasters.

References

1. NCSL SOP Scope of Practice Policy Website. https://scopeofpracticepolicy.org/. Accessed December 22, 2020.

2. COVID-19 Related State Actions. Center for Connected Health Policy Website. https://www.cchpca.org/covid-19-related-state-actions. Accessed December 22, 2020.

3. Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19. Manatt Website. https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat. Accessed December 22, 2020.