



The Our American States podcast—produced by the National Conference of State Legislatures—is where you hear compelling conversations that tell the story of America’s state legislatures, the people in them, and the policies, process and politics that shape them.

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Helping Health Care Workers Cope | Aug. 15, 2021 | OAS Episode 139

Ed: Hello and welcome to “Our American States,” a podcast from the National Conference of State Legislatures. This podcast is all about legislatures: the people in them, the policies, process and politics that shape them. I’m your host, Ed Smith.

“Recent reports indicate that 60% of physicians, nurses and medical residents report having anxiety, depression and insomnia during these periods of COVID, and that certainly is troubling because that has an impact both on the individual, but also on the patients and the communities that they serve.”

That was Dr. Luis Padilla, the associate administrator for Health Workforce at the Health Resources and Services Administration (HRSA). Padilla also serves as director of the National Health Service Corps. He’s one of my guests on this podcast focused on the health care workforce and how it has fared during the pandemic.

The crushing strain of caring for patients this last year and a half of the pandemic has taken a toll on health care workers. Dr. Padilla discusses how HRSA supports states in strengthening the workforce in helping health care workers cope with the current challenges. He also talked about the growing role of telehealth and the important role states have in regulating scope of practice rules.

My second guest is Sydne Enlund from NCSL. Enlund tracks scope of practice laws across the country and maintains a website on the topic with interactive maps dealing with nurse practitioners, physician assistants, pharmacists, and more. She discusses the role legislatures have played in modifying regulations for workers during the pandemic.

Here’s our discussion. Dr. Padilla, welcome to the podcast.

Dr. P: Thank you, Ed. Glad to be joining you today. Thank you.

Time Marker (TM): 01:59

Ed: Dr. Padilla, thanks for coming on the show to discuss the health care workforce. I think even those of us who don't work in health care realize the pandemic had a huge effect on health care workers. I was going to ask you this question prefaced with: "as the pandemic recedes," but it looks like that may not be the case.

Instead, let me ask you: As we continue to live with this pandemic, what's the current landscape of the health care workforce? What trends are you seeing?

Dr. P: Sure, thank you, Ed. Certainly, as you said, the pandemic as hoped is not waning; it's not quite over. These variants and the ongoing infections and surges in infections have certainly taken their toll on everyone, particularly the workforce.

But as it relates to the current landscape, as you said, the focus is on addressing the pandemic in the United States, and our health care providers have been at the forefront of this. And HRSA, through its various workforce programs, has been supporting them in various ways.

But in terms of trends that we're seeing, I think on a positive and interesting note has been the increased use of telehealth services and remote services for patients to access services during COVID. And certainly, HRSA has been involved in this for decades. Last year it launched [telehealth.hhs.gov](https://www.hhs.gov/telehealth) to help patients and providers maximize the use of telehealth during the coronavirus and public health emergency. And during this last year, we've also awarded over 54 million across various programs to support COVID-related telehealth activities.

So, I think overall what we've seen here is the rapid increase in use of telehealth technologies, and it's not been relegated just to services. We've seen an increased use of those modalities to train current and future workforce participants as well. So, that's on the upside.

I think the other thing that is trending unfortunately is the issue of burnout, clinician burnout, and addressing resiliency among these same health care providers who have been struggling with the pandemic and addressing the pandemic for over 16 months. Recent reports indicate that 60% of physicians, nurses and medical residents report having anxiety, depression and insomnia during these periods of COVID, and that certainly is troubling because that has an impact both on the individual, but also on the patients and the communities that they serve.

There's increased absenteeism because of that, there's reduced productivity, increased errors, and perhaps safety lapses as a result of that. And certainly, patients may not always get the best care that they can because of the providers struggling with these issues.

So HRSA has responded by recently releasing 103 million to address provider resiliency, mental health, and support organizations in creating an organization of wellness within the organizations which employ health care providers. We're excited about that. That application cycle is open right now. We're going to support 40 awardees, 41 including the technical assistance award that we're putting out, to provide support to frontline providers and organizations to address burnout and resiliency among providers.

TM: 05:06

Ed: Well, I think all of us can relate to the burnout you're describing. It's hard to imagine what it must have been like for nurses, doctors and other health professionals over the last year and a half.

Now, states are increasingly turning to nonphysician providers to provide health care services in places where physicians are sparse. What are some ways states can use nonphysician providers to improve access to health care? And what sort of strategies are available to policymakers?

Dr. P: As you've been talking about, the COVID pandemic has had a profound impact on our health care delivery and its workforce and, as you mentioned, many states have responded with efforts aimed at building or rebuilding or expanding that workforce to address these surges and their capacity to address their response.

So, many states have put into place regulatory and policy changes aimed at expanding the workforce capacity and supporting telehealth, for example. Many states have expanded scopes of practice for nonphysician providers. Reimbursement policies have changed in some states to allow greater reimbursement for, for example, peer support counselors, community health workers, etc.

So, certainly states have stepped up as well as the federal government in looking at how other members of the care team who are nonphysicians or other professional providers may be better utilized to address not just COVID, but overall, what's at the heart of this is this ever-growing demand for services.

We do have shortages of certain providers including primary care providers, and we're looking at ways to expand that care team and expand scope of practice for those who are currently out in the field.

As you know, the federal government doesn't regulate scope of practice; that's in the purview of the states. But there have been a number of states that have looked at this as an access issue and have addressed some of the scope of practice. In particular, we note that there are practitioners and PAs who, though they are not substitutes for physicians or other professionals, certainly provide a needed source of access to high-quality care and oftentimes fill in the gaps where there are shortages of primary care providers.

TM: 07:15

Ed: Well, there has certainly been a lot of action by states to temporarily modify scope of practice rules during the pandemic. From what you see, do you think many of these changes will become permanent?

Dr. P: It depends on the changes that states made. Certainly, in terms of scope of practice, I think they're likely to be more permanent because they're codified and there are licensure expansion policies that were put in place. And I think that as states continue to look at their workforce needs, their capacity to meet those needs and their capacity to meet access constraints, they're

going to look more and more to other professionals, paraprofessionals that they can leverage to expand that care team.

Just to highlight what HRSA does in the states, we have a number of programs that support nurses, advanced nurse practitioners, physician assistants, community health workers, allied health professionals, paraprofessionals. So, HRSA has certainly been on the forefront of supporting various disciplines to provide quality accessed care.

TM: 08:16

Ed: Well, pharmacists are an example of a nonphysician practitioner with whom many people have become more familiar during the pandemic, because that's the person who gave them a COVID-19 shot.

Recently, we've seen states using pharmacists more and more as primary care providers. How are states accomplishing this and what kind of care can pharmacists provide?

Dr. P: That's generally in the purview of the states, not at the federal level. HRSA and HSS have certainly been involved in the expansion and use of pharmacists to provide vaccinations. I will say that the expansion of services for pharmacists to provide vaccines is important, as we've clearly seen with COVID, but also filling in and utilizing pharmacists to provide child vaccines has been an important part of this COVID response.

But I think overall, I would probably say that question could probably be better answered by those individual states that are putting these changes in their pharmacy policies in place.

TM: 09:16

Ed: Let's go back to the topic of telehealth. You talked about its utilization during the pandemic and HRSA's support of those efforts. I wonder if you think the pandemic has improved our ability to do telehealth and if you think this expansion of these efforts is here to stay.

Dr. P: As I said, HRSA has been involved in telehealth expansion for decades now and it is committed to looking at resources that will expand the use of telehealth services. I think that from a workforce perspective, we too are looking at and we were fortunate to get about 15 million dollars to provide funding for awardees that will enhance their ability to use telehealth services, train their future workforce in effectively using that modality.

But I do think that these services are likely to continue in some form or fashion. We've already seen some retreating of those as organizations have opened up and are having more face-to-face visits. And I would also say that the changes that CMS made to its reimbursement, which included being able to conduct telehealth visits with patients located in their homes outside of those designated rural areas, being able to use multiple modalities, both video and audio, being able to care for not just established patients, but new patients – these were all flexibilities that CMS afforded during the pandemic and those changes are being looked at in terms of which ones might continue beyond the pandemic.

I think that what we once thought was an experiment of telehealth we realize is now a reality. And the issue is: How much of it will hold? How much of it will translate into regular practice? But I believe going forward, I mean, by all indications I think health care delivery organizations have realized they can use this, particularly in mental health where we've seen reductions in no-shows, where we've seen greater access to mental health services – I think we're finding that users and patients of this modality are much more comfortable than ever because it's been such a rapid deployment.

TM: 11:16

Ed: Dr. Padilla, as you know, our audience is mainly legislators, legislative staff and others interested in state policy. Particularly with those policymakers in mind, are there any other trends you're seeing where they could take action?

Dr. P: We talked a little bit about it earlier, Ed, and you mentioned the expansion of states in using other disciplines. The other area and certainly this administration, the Biden/Harris administration and the department are very interested in expanding the use of community health workers, particularly in the areas of public health. I think that some states are already responding to that.

HRSA has put out funding to support community-based organizations to train that current community-based workforce, and I think that's another area for states to continue to look at: How can they expand community health worker disciplines within their states? These are individuals that often live in the same community they serve. Oftentimes some of them may have conditions that they support patients with, whether it's diabetes, hypertension. Peer support counselors have lived experience, for example, in terms of addiction. Very effective in terms of guiding patients, increasing access to key services, keeping them involved in their care treatments and plans.

So, we see that as another trend that's likely to continue, that is that expansion and use of community health workers. I just wanted to highlight.

The other one is the ongoing trend in terms of integration and peace services, whether it's behavioral health and physical health, or now in this age of COVID and beyond, the integration of public health and primary care or other services.

I think we're finding more and more that it's a porous endeavor if you will – you really can't separate the treatment of that individual from the population or community they're in. In terms of behavioral health, you really can't separate the behavioral health needs from the physical needs of that individual and those communities.

I think we're recognizing this more and more in this pandemic; it's showing us exactly that – these things are interrelated. So, I think these are the trends that both the federal government, certainly HRSA and BHW and states are looking at.

TM: 13:24

Ed: That notion of interconnectedness across sectors of society has come up so often in my discussions with people during the pandemic. I'm sure many listeners will find that rings true.

As we wrap up, it's always helpful for legislators to have evidence-informed resources, both for themselves and to share with their constituents. Can you offer some recommendations?

Dr. P: I think in the area of telehealth, going to HRSA's website around telehealth services. Our federal office of rural health policy has a wonderful resource there. That's one. The other that we produce, and we support, is through our Health Workforce Technical Assistance Center that supports the efforts of our National Center for Health Workforce Analysis, and there's a host of resources there.

They've been very active. Our nine health workforce research centers have been very active during COVID, putting an enormous amount of research and information out there.

And then we have just data that policymakers can utilize. The notable ones here are our area health resource files where anyone who goes to our site can find information by health profession, clinical data per population, and then the total clinician count as well.

I would refer your audience to data.hrsa.gov, our website, where they would find maps, data, portals, reports and dashboards around our various programs, findings from our various awardees, and then tools to help them assess what may be some of the workforce needs within their state.

Ed: Dr. Padilla, thanks again for taking the time to explain the challenges facing health care workers at this juncture. Take care.

I'll be right back after this break with Sydne Enlund from NCSL.

MUSIC and Female VO

NCSL's Legislative Summit is back. Connect with your colleagues November 3rd through 5th in sunny Tampa, Florida to gain unique insights and practical knowledge and drive results for your state. Early-bird pricing available through August 31st. Register today at www.ncsl.org.

Ed: I'm back with Sydne Enlund from NCSL. Sydne, welcome to the podcast.

Sydne: Thanks so much for having me, Ed.

TM: 15:52

Ed: Sydne, thanks for taking the time to be on the show. I know you've spent the past few years tracking how states are licensing and creating rules for nonphysician health care providers. In fact, we worked together on a website focused on the issue.

I understand that one trend you've seen during the pandemic is an increase in states joining interstate compacts. Can you tell us what an interstate compact is, what kinds of compacts are out there, and which states have seen increased activity in this area?

Sydne: Licensure compacts have gained traction really as a way to allow various types of health professionals to provide services to individuals in other states. Compacts are formed when a certain number of states enact legislation that includes specific, uniform language or by a certain date, whichever one of those occurs first.

So, after a state joins a compact, the compact is administered by a nongovernmental organization. However, joining the compact is still voluntary for providers. There is a variety of active compacts out there for different health care professionals: doctors, nurses, psychologists, physical therapists, among others. Advanced practice registered nurses and licensed professional counselors are also hopeful to enact a compact in the coming years.

A few state examples include Kansas, Maine, Maryland and Tennessee passing legislation this year to join the psychologist compact, and Alabama and Indiana have enacted legislation this year to join the physical therapy compact.

TM: 17:38

Ed: I know one goal with the work in this area is to boost the use of nonphysician providers, especially in rural and underserved areas. Can you give some examples of where this effort is working?

Sydne: We've seen a large increase in states using pharmacists to improve access to care. Nine out of ten Americans actually live within five miles of a community pharmacy, making pharmacists some of the most accessible health care professionals.

Along with dispensing medications, they can play an important role in enhancing public health and increasing access to care in coordination with other health care providers. Pharmacists are often the first line of contact for patients in rural communities, and they can help patients manage medication and address chronic illness.

We've also seen states using professionals such as community health workers and peer support specialists to extend the region capacity of existing health care providers in communities. They can connect patients with services and offer support, education and disease management in-between other health care provider visits.

These professionals are often existing members of the communities they serve with established relationships, and they sometimes draw on their personal experiences and knowledge when providing service.

TM: 19:02

Ed: Well, I got my COVID vaccine from a pharmacist and that made it very easy to get in for the shot. Now, what other trends have you seen during the pandemic regarding modifying scope of practice for nonphysician providers?

Sydne: Generally, we've seen legislation proposed on modifying supervision requirements, especially for physician assistants and nurse practitioners, expanding the procedures a provider is allowed to do, or even the types of practice settings providers may provide care in.

These topic areas are examples of what states have looked at prior to and during the pandemic to increase access to care. Although throughout the pandemic, we've seen states modifying practice requirements mostly, many states have waived or suspended supervisory or collaborate agreements for the duration of the public health emergency.

And after those states of emergencies were declared, and in some cases even before the pandemic, several states modified statutory language allowing nurse practitioners and physician assistants to practice at a different site than the physician was practicing. In these cases, communication is still required between the nurse practitioner and physician assistant and the supervising physician.

States have also increased the number of nurse practitioners and physician assistants a physician is allowed to supervise. Prior to the COVID-19 pandemic, some states allowed a physician to supervise only one, two or three nurse practitioners or physician assistants. In response to the pandemic, some states have increased the number to five or sometimes even more.

A majority of these policies were through executive order and are only in place through the duration of a declared emergency. This is an area we continue to track closely as we head into 2022 to see if states will make any of these changes permanent.

TM: 21:04

Ed: I think we've seen that kind of flexibility at the state level in a number of areas during the pandemic, so it's not surprising you're seeing it with these health care professionals.

So, for our listeners who want to learn more about this topic, does NCSL have any additional workforce resources available?

Sydne: Well, hot off the press we just released a toolkit called the Telehealth Explainer Series and it features seven different two- to four-page briefs focused on a variety of telehealth topics including Medicaid, licensure and COVID-19 state actions. It's featured on the NCSL website.

NCSL also maintains a website called scope of practice policy featuring nonpartisan information on state laws governing the practice of eight health care professions. Eighteen interactive maps provide snapshots of the variable scope of practice laws and regulations across the nation. Be sure to check it out at scopeofpracticepolicy.org.

Ed: I'll be sure to link to those resources from the podcast when it's posted on ncsl.org. Sydne, thanks for filling us in on how states are dealing with this issue. Take care.

MUSIC

Ed: And that concludes this edition of our podcast. We encourage you to review and rate our episodes on iTunes, Google Play or Spotify. You may also go to Google Play, iTunes or Spotify to have these episodes downloaded directly to your mobile device when a new episode is ready. For the National Conference of State Legislatures, this is Ed Smith. Thanks for listening and being part of “Our American States.”