

How the crucible of COVID-19 can help fix the health care system

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The COVID-19 pandemic has demonstrated the irreplaceable nature of physicians and other front-line health professionals. But it has also exposed many of the chronic frailties and shortcomings of the U.S. health system, and how those flaws are pushing the workforce to the brink.

A discussion paper from the National Academy of Medicine (NAM), "Clinicians and Professional Societies COVID-19 Impact Assessment: Lessons Learned and Compelling Needs," identifies the biggest challenges to doctors and other clinicians during the pandemic response and suggests priority actions for revitalizing the health care system to meet population-health needs, promote the well-being of health professionals, and head off future public health emergencies.

While physicians, nurses and other health professionals "have been remarkably adaptive, innovative, and resilient during the pandemic, verbal salutes alone are insufficient to address the systemic workforce challenges exacerbated by COVID-19," the NAM paper says. It was co-written by James L. Madara, MD, CEO and executive vice president of the AMA, the organization's President-elect Jack Resneck, Jr., MD, and Mira Irons, MD, the AMA's chief health and science officer, along with experts from the American Academy of Nursing, the National Black Nurses Association, Harvard, Johns Hopkins and Stanford.

"Tangible and long-term investments in training, operations and financing are needed to shore up the clinical capacity needed to care for future generations," the NAM paper continues. "A special focus on mental health, particularly efforts to reduce burnout and promote workforce well-being, will be needed following the pandemic."

What needs fixing

The report highlights systemic issues afflicting the health care sector in these four key areas.

Well-being and occupational distress. Some 35%–45% of clinicians had high levels of burnout prior to the pandemic, and COVID-19 added numerous stressors, such as personal health risks, separation from families due to isolation requirements, anguish from caring for high volumes of acutely ill patients, and combating misinformation in their communities.

Staffing and operations. Shortages of health care workers in intensive care units required rapid both geographic redeployment to COVID-19 hot spots and cross-training from different specialties. The lack of interoperability among data systems and EHRs undermined admissions and discharge decision-making, as well as enrollment for clinical trials.

Education and training. Interruptions to clinical training, research projects and laboratories have disrupted university finances, caused career delays and highlighted the unaffordability of medical education. In addition, systemic racism and uneven access to remote learning have disproportionately affected students of color.

Financial and administrative impacts. Delays in visits unrelated to COVID-19 and cancellation of nonemergent procedures disrupted revenue streams and threatened the sustainability of physician practices. The stress and workload of the pandemic also made it harder for doctors and other health professionals to comply with administrative requirements, such as quality-measure reporting and burdensome prior authorization requirements implemented by health plans.

Where to start

The discussion paper also notes five ways policymakers, regulators, employers, medical schools and professional societies should respond.

Invest in well-being. This includes: rebuilding trust with front-line workers; acting on the recommendations in NAM's 2019 report on clinician well-being; strengthening protections for health professionals who report safety and ethical violations; training leaders in behaviors that promote well-being, equity and inclusion, and how to recognize distress and impairment; and removing stigma and barriers to the use of mental health resources.

Advance innovations in clinical practice. The authors' recommendations span data-sharing infrastructure, workforce development and standardization of protocols. They also include evaluating internal review and oversight processes to speed up needed research efforts and publication of evidence-based practice guidelines during crises.

Promote financial resilience. This starts with developing and funding payment models that support high-quality, team-based care. It also involves building on COVID-19 reporting flexibilities to cut

administrative burdens associated with prior authorization, establishing ways to support patient access and continuity of care during crises, and creating coverage and payment policies that promote ongoing availability of telehealth services.

Transform education and training. Besides addressing financial barriers to access, health professions education should: address the drivers of inequities in learners' resources and experiences; expand competency-based, time-variable education; and advance innovation in simulation for continuous learning.

Develop policies and programs to address health inequities. At its core, this involves developing fair, equitable and transparent plans for allocating resources and access to care, with adjustments made for people who are systematically disadvantaged. This also should include comprehensive inquiry into how racism might be in play in decisions or plans, as well as ongoing surveillance of the impacts of decisions and protocols on staff.

"A resilient health care system begins with a resilient health care workforce, and by addressing the systemic challenges exposed and exacerbated by the pandemic, policymakers can support and revitalize the clinician workforce to meet the health and care needs of patients and communities across America for COVID-19 and beyond," the authors wrote.

The AMA COVID-19 resource center offers frequent updates on clinical information, AMA guides and resources, advocacy and medical ethics related to the pandemic.