(it has since been disbanded), the government has made repeated attempts to incorporate comparative clinical- and cost-effectiveness analyses into formulary decisions. In another major setback for these efforts, the 2010 Affordable Care Act prohibited the Patient-Centered Outcomes Research Institute (PCORI) from conducting cost-effectiveness analyses. Although the recent Congressional reauthorization of PCORI has introduced some flexibility for the institute to "take into account" the potential economic effects of health plan benefit and formulary design, the statute establishing PCORI still forbids the use of "dollar-per-QALY" thresholds to define cost-effectiveness. In the absence of governmental guidance, independent groups such as the Institute for Clinical and Economic Review have stepped in with their own analyses of pricing structures, which have galvanized a national debate about value-based drug prices.

To reach a point where the United States can abandon the anachronistic specialty-drug label that fails to distinguish between high-cost drugs that do and those that do not offer good value for the money, public payers could learn from their counterparts in other high-income countries and formally consider clinical- and cost-effectiveness in their funding decisions. As a first step, CMS could eliminate its cost-based threshold for defining specialty drugs in Medicare Part D and instead require health plans providing prescription-drug benefits to make value-based coverage and tiering decisions. The same process could then be used for setting reimbursement levels for physician-administered drugs in Medicare Part B. We believe that patients and the health care system would benefit from evidence-based formulary designs that more accurately reflect drugs' clinical benefit and economic value.

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Ensuring and Sustaining a Pandemic Workforce

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Current efforts to fight the Covid-19 pandemic aim to slow viral spread and increase testing, protect health care workers from infection, and obtain ventilators and other equipment to prepare for a surge of critically ill patients. But additional actions are needed to rapidly increase health workforce capacity and to replenish it when personnel are quarantined or need time off to rest or care for sick family members. It seems clear that health care delivery organizations, educators, and government leaders will all have to be willing to cut through bureaucratic barriers and adapt regulations to rapidly expand the U.S. health care workforce and sustain it for the duration of the pandemic.

As hospitals and nursing homes gear up for expected increases in critically ill patients, they should examine all opportunities to expand their workforce capacity. Where the threat of postpandemic legal consequences hampers action to expand capacity, such barriers could be removed by governors enacting emergency orders that modify or temporarily rescind medical malpractice policies that inhibit health professionals' ability to expand their scope of practice as required. Most organizations, however, will find that outdated internal policies such as workflows, task-delegation protocols, or union agreements are the main culprits in restricting the shifting of tasks and responsibilities among personnel. These restrictions can be

changed to allow health workers to fully use their knowledge and skills. How changes are accomplished will vary among organizations, but it's essential to involve staff in identifying barriers and implementing strategies to overcome them: no one has all the answers, and engaging frontline workers can be empowering and can facilitate difficult decision making.

Public and private payers play a critical role in increasing the workforce's capacity to meet patients' needs. The Centers for Medicare and Medicaid Services (CMS) has taken unprecedented steps through the 1135 waiver program[1] and expanded telehealth coverage[2] to increase the flexibility of Medicare, Medicaid, and Children's Health Insurance Program payments, expanding the types of services that can be covered, broadening the number and types of providers eligible for payments, and allowing services to be provided in a wider range of settings, including patients' homes. Governors can propose additional flexibility in their Medicaid programs by requesting waivers. Some private insurers have unilaterally expanded their coverage, and these efforts should be encouraged. Efforts need to focus not only on increasing workforce capacity, but also on sustaining it over the course of the pandemic. CMS has also issued guidance allowing hospitals to provide benefits to support staff, such as multiple daily meals, laundry service for personal clothing, or child care services.

While government and private efforts focus on obtaining and producing ventilators, hospitals will require personnel who can operate these machines. Hospital associations can develop strategies to deploy respiratory therapists to the hospitals most in need and to develop programs to quickly train workers who can operate this technology competently; respiratory-therapy education programs can accelerate the preparation of therapists.

Medical students in their third and fourth years who are no longer in clinical rotations can help expand the workforce by performing various medical tasks to free up clinicians for Covid-19 care. They can, for example, triage and assess patients, collect and analyze data needed for institutional decision making, and perform administrative tasks. Hospitals have suspended students' access to their facilities in order to preserve scarce supplies and focus on their care delivery mission. But because students need clinical skill development and clinical hours to satisfy graduation requirements, it's important to find ways to adapt these restrictions to avert a bottleneck in the educational pipeline. Tens of thousands of U.S. students in the final semester of their education program could help create surge capacity and sustain the workforce if the pandemic is prolonged.

To assist hospitals in meeting this challenge, education programs can develop classes to train students in the skills most immediately needed. Accreditation bodies can allow students to count work hours toward graduation requirements. State licensure organizations can issue emergency or temporary licenses to fourth-year medical students, and to nurse practitioner, physician assistant, registered nurse, and other health profession students who are near the end of their programs. Students' health care organizations can waive the background checks that most require as a condition of employment. Inflexibility and lack of creativity could stall efforts to expand the current workforce and jeopardize longer-term workforce stability at a time when health workers are critically needed.

Organizations can also expand workforce capacity by identifying health care professionals who have either retired or temporarily left the workforce and encouraging them to return to work. Using this strategy, New York City recently saw 1000 retired physicians and nurses volunteer to rejoin the workforce in a single day.[3] Other states' licensure boards could immediately reinstate the licenses of professionals whose credentials expired in the past 3 years.

There are many other opportunities for creating surge capacity. Dentists, dental hygienists and assistants, dental therapists, optometrists and optometry technicians, chiropractors, and hearing technicians are among those whose practices have closed because of Covid-19. Such health professionals can be trained to conduct screenings, take vital signs, provide telephone follow-up of quarantined people with Covid-19, collect epidemiologic data, and provide community education. Short online courses and training documents could be developed to prepare these workers for such roles and to quickly scale up the capacity of the community workforce.

It's also important for community health leaders to plan for the needs of millions of people in the United States who require treatment for mental health dis-

orders. Health care providers, patients in isolation, and people affected by shelter-in-place orders are likely to experience considerable psychological distress. Not to be forgotten are people suffering from inadequate housing, food insecurity, isolation, and low income, who are vulnerable to being left behind as social and economic reactions to the pandemic intensify. Social workers are pivotal in helping vulnerable people by providing mental and behavioral interventions and helping people access food, housing, and social services. Health care organizations and health departments can also partner with community health workers, peer-support workers, occupational and physical therapists, and home health workers to identify and attend to social needs, including helping patients with Covid-19 adhere to their medical treatment.

Government leaders and regulators will need to help expand capacity and ensure the full use of our workforce throughout the pandemic.[4] As seen in Europe, China, and now the United States, the effects of Covid-19 are regionally concentrated. Health care workers need to be able to offer telehealth services across state lines and provide triage, screening, monitoring, and counseling. States will therefore have to allow out-of-state licensed professionals to practice under emergency authorization, even if they're not part of interstate licensing compacts. It serves no purpose to limit use of our telehealth capabilities because of legal restrictions and regulations, particularly when the population is being asked to stay at home. Physicians, nurse practitioners, physician assistants, respiratory therapists, pharmacists, clinical psychologists, marriage and family counselors, mental health specialists, peer-support therapists, licensed social workers, and others should be allowed and encouraged to use this tool.

An audio interview with Dr. Fraher is available at NEJM.org

Finally, governors and state regulators should examine regulations to determine whether health professionals' scope of practice is being unnecessarily restricted. Nurse practitioners can practice safely without formal physician oversight, and there may be unnecessary restrictions on registered nurses and licensed practical nurses. As more patients require care provided by registered nurses, licensed practical nurses and nursing and home care assistants could be trained and authorized to provide more services to ensure continuity of care, especially for vulnerable and frail older adults.

How well the country handles the Covid-19 crisis depends largely on how effectively our health workforce is used. Much can be done to ensure that the workforce is prepared to defeat the pandemic. Some actions discussed here are temporary, whereas others — such as expanding scopes of practice, cross-state licensure, and allowing greater use of telehealth services — probably make sense in general but are especially critical now. Now is the time for pragmatic steps to expand and sustain the health workforce. Once the pandemic has subsided, workforce changes should be evaluated and the results used to inform wiser use of the workforce and improved responses to future pandemics.

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