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Expanded roles of registered nurses in primary care delivery of the future

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ABSTRACT

Background: Primary care in the United States is changing: practice size is increasing, there is a growing shortage of primary care practitioners, and there is a heightened prevalence of chronic disease. Given these trends, it is likely that registered nurses will become important members of the primary care team.

Purpose: This paper explores the challenges and opportunities in primary care delivery in the 21st century and examines the likelihood of expanded roles for RNs to improve quality and add capacity to the primary care workforce.

Methods: We searched the peer-reviewed and gray literature for publications on primary care, primary care workforce projections, the future of nursing, and team-based care.

Discussion: The number of primary care physicians is expected to decrease in relation to the US population while the number of nurse practitioners is increasing, with the result that more and more patients will see nurse practitioners as their primary care practitioner. However, the primary care practitioner (physicians, nurse practitioners and physician assistants) to population ratio is dropping. As a result, other professionals will be needed to deliver primary care. As the nation's largest health profession, registered nurses (RNs) are in sufficient supply and have been shown to improve the care of patients with chronic conditions. It is likely that primary care practices of the future will include an enhanced role for RNs, particularly in chronic disease management..

Conclusion: For RNs to assume an expanded role in primary care, several barriers need to be overcome: (1) the widespread introduction of payment reform that reimburses RNs to independently provide care for patients, and (2) nursing education reform that includes primary care nursing skills (3) scope of practice clarification for non-advance practice RNs working under standardized procedures.

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A vibrant national movement is sweeping primary care, spawning high-performing patient-centered practices. The numbers of nurse practitioners (NPs) and physician assistants (PAs) are growing, adding to the primary care practitioner (PCP) workforce (Auerbach et al., 2013a). Discussions are intensifying on payment reform, which supports the evolution from a physician-does-everything model to team-based care (Ghorob & Bodenheimer, 2012).

Yet the challenges are formidable. Society expects primary care practices to provide accessible and

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comprehensive care to the American population, but primary care is underpaid, receiving only 5% of the total health care dollar (Mostashari, Sanghavi, & McClellan, 2014). Panel sizes are large, making it difficult for practitioners to spend sufficient time with patients (Yarnall et al., 2009). In addition to providing 20 to 25 daily patient encounters to an aging population, PCPs are tasked to measure and improve a potpourri of performance measures (Blumenthal & McGinnis, 2015). With these increasing demands and insufficient resources, practitioner burnout is a serious and persistent problem (Shanafelt et al., 2015). The growing prevalence of multiple chronic conditions requires primary care to add a robust care management function, generally performed by registered nurses (RNs) who are not yet present in many primary care practices.

Chronic disease management ensures planned, timely, and quality care by team members actively managing the care of patients with chronic disease. This is accomplished by identifying patients' medical and social needs, assuring that chronic and preventative care needs are met (e.g., routine laboratory tests, eye and foot examinations), reconciling medications, overseeing and supporting patient self-management, and coordinating care transitions (Bodenheimer, Wagner, & Grumbach, 2002a, 2002b).

This paper explores the challenges and opportunities in primary care delivery in the 21st century and—in light of the growing importance of chronic disease management—examines the likelihood of expanded roles for RNs to improve quality and add capacity to the primary care workforce.

The Central Role of Chronic Disease in Primary Care

Currently, 75% of primary care visits address chronic illnesses (Zamosky, 2013). In 2012, 50% of U.S. adults had at least one chronic condition and 12% had three or more chronic conditions (Ward, Schiller, & Goodman, 2014). The U.S. population of age 65 years and older grew from 25.5 million in 1980 to 46.2 million in 2014 and will add almost 2 million people yearly, up to 82.3 million in 2040 (A Profile of Older Americans. U.S. Administration on Aging, 2015). Eighty-six percent of the elderly population has at least one chronic condition and 33% have three or more chronic conditions (Ward, Schiller, Goodman, 2014). Over one-third of U.S. adults are obese and over two-thirds are overweight (Flegal, Carroll, Kit, & Ogden, 2012). Without serious prevention efforts, the U.S. prevalence of diabetes will grow from 41 to 61 million from 2015 to 2030 (Gregg et al., 2013).

These realities underlie the widespread adoption of the essential elements of the Chronic Care Model: community resources and policies, health care organizations, self-management support, delivery system design, decision support, and clinical information systems (Wagner, 1998; Wagner et al., 2001). New team-based delivery systems are essential for chronic disease management, where an informed, activated patient interacts with a prepared and proactive practice team (Bodenheimer et al., 2002a, 2002b). RNs, in particular, could play a major role as chronic disease care managers to oversee and coordinate chronic care management activities in these new delivery systems (Shojania et al., 2006).

Trends in Primary Care Practice

Historically, primary care was practiced by family physicians, general internists, and general pediatricians. During the last decades of the 20th century, the new professions of NP and PA appeared, and from 1999 to 2009, the number of physician offices with at least one NP, PA, or certified nurse midwife increased from 25% to nearly 50% (Peterson et al., 2013).

In this paper, the phrase "primary care practitioner (PCP)" refers to the aforementioned primary care physicians (as well as NPs, and PAs)—those who are authorized to diagnose and treat and who can bill for their services. The broader term "clinician" includes PCPs and other professional team members, for example, RNs, pharmacists, and behavioral health professionals.

Practice size is undergoing a major change. The percentage of physicians in solo practice declined from 41% in 1983 to 18% in 2014 (Kane & Emmons, 2013); primary care is experiencing similar trends. The percentage of physicians in practices of 50 physicians or more grew from 3% in 2001 to 36% in 2011, with similar trends for primary care (Welch, Cuellar, Stearns, & Bindman, 2013). Because larger practices are more likely to have resources to hire and train RN care managers, the practice size trend facilitates greater RN involvement in primary care.

The pillars of primary care, first contact care (access), continuity, comprehensiveness, and care coordination, are facing major challenges because of the trend toward part-time practitioners and the hospitalist movement, fracturing the natural familiarity between primary care physicians and specialists (Starfield, 1998; Meltzer, 2015). NPs and PAs, whose patients have health care outcomes generally equivalent to those of physicians, have played an essential role in improving both access and continuity (McCleery & et al., 2011). Practices are increasingly hiring RN care coordinators to assist patients in coordinating care within the medical neighborhood surrounding the primary care home—the specialists, ancillary services, pharmacies, hospitals, long-term care facilities, home health agencies, and other services that the medical home needs to provide comprehensive care to its patients. (Fisher, 2008; Naylor & Kurtzman, 2010).