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The Potential of Registered Nurses as Physician Extenders in Primary Care Clinics

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Perspective

While there are numerous studies of the potential of Nurse Practitioners as replacements for primary care physicians to our knowledge none have explored the potential of Registered Nurses (RNs) as physician extenders in primary care settings. The studies of efficiency gains of RNs are largely focused on hospitals or on how clinic nurse staffing varies and influences the number of patient visits provided by physicians [1-3]. Our recent study of two Family Medicine clinics that restructured the way they provided primary care with RNs working at the limits of their training provides insights into the potential of these clinicians and the challenges encountered in achieving those goals [4].

Our study included two Family Medicine clinics one with nine FTE physicians and the other with eleven FTE physicians. Both are members of a large health care system with thirty-one clinics and three hospitals. They established four major goals for the transition. First to develop an open access system with phone and electronic access portals in addition to the traditional appoint system and walk in visits. Second rapid response to patients with a goal of appointments with a usual provider within ten days for routine visits, access to a provider within twenty minutes for walk in patients and response to phone and electronic patient inquires within thirty minutes if not resolved immediately when received. Three to create clinical teams with RNs providing unsupervised patient care using care guides and freeing physician and nurse practitioner time to provide backup care as well as providing consultation for the RNs. And four to expand the EHR system so that all the clinical team members and the triage nurses have immediate access to patient records and to the availability of other team member so that they can link patients with whoever is available and get consults if needed.

When the model was fully in place only three patients were scheduled per clinic hour for physicians and nurse practitioners so they had time to provide the backup needed by the other clinicians and for walk in visits. Forty percent of the visits were conducted by phone or electronically, thirty eight percent of all visits were being provided by RNs using care guides and all of the response time goals were being met. Patient care costs were reduced by twenty three percent and patient satisfaction improved. Some examples of the clinical services provided by the RNs included treatment of patients with sore throats, vaginitis, and sinus infections and adjusting medications for patients with hypertension. One of the services most appreciated by patients was the counseling and advice provided to new moms after they went home with their babies.

The transition to this model encountered significant challenges. First they needed to determine the services that could be provided by RNs. They did this by reviewing all of the clinic visits for the past six months from the clinic EHRs. These data were then reviewed by two physicians and a nurse practitioner and were categorized according to level of clinical skill needed to resolve the issues. They concluded that nearly half of these visits did not require physician level skills and that most could be conducted by RNs. Second they needed to develop a training and support program designed to empower the RNs to conduct as many of these visits as possible. This included development of care guides a training program focused on the use of those guides a buddy system where more experienced nurse sat in on phone and clinic visits with those less comfortable with their new roles and scheduled team huddles to reinforce the team concepts and help those with clinical questions. The implementation of this team concept received mixed reactions from both the nursed and the physicians. Some of the physicians were unable to make this transition. They were not convinced that RNs could provide unsupervised patient care and were unwilling to give up some of their direct patient care to the nurses. They were unable to shift from a "my patients" to an "our patients" concept of team care. One third of the physicians left the clinics and joined traditional practices. This turned out to be useful in that the clinics were able to attract replacements who were enthused about the potential of this patient care model and this helped further the team care concept. The RNs were very enthused about the new patient care model and were highly committed to making it work. However they found the transition to independent care givers to be very difficult. As one nurse said "after ten years of doing what the doctor asked me to do I was now providing patient care independently under protocols and it was a steep learning curve" The care guides and the availability of NPs and physicians for consults and huddles were very useful but even after the program was up and running for a full year about one third of the RNs were still referring patients that they could have treated to the NPs or physicians for care. Another challenge was the structural design of the clinics. The care teams needed space for huddles and quick consults and the space was not designed for those needs. In part this was resolved by greatly expanding the EHR system so that all of the clinical team members had access to patient records at their care stations and could communicate with other team members and a pharmacist if they needed help. Even then the design of the clinic continued to limit the full potential of the team concept. Finally although the total cost of patient care decreased by twenty three percent the clinics lost over one million dollars the first year because

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most of the services provided by RNs were not billable at the same level to the health insurance plans. The health insurance plans were sympathetic but were unable to respond and the clinics were forced to engage the providers more in order submit more claims under a doctor's billing ID, at a higher level and this decreased the expanded role of the RNs.

What can policy and practice stakeholders learn from these experiences? First access to health care can be greatly improved and costs reduced by expanding the clinical roles of RNs in primary care clinics. Second this will not happen without changing the clinic payment systems. The current RVU based payment system will not support these innovations. Third, the clinical education programs need to recognize the great unrealized potential of clinical teams that can be achieved by better preparing both physicians and nurses for a different configuration of their roles. Retraining them after graduation is very difficult and very expensive. Finally researchers need to clearly document the quality and economic gains that can be achieved by alternate configurations of these team care models. Medical group practices will not adopt these models if they believe they will lose money by doing so and health insurance plans will not develop payment systems to support these models until efficiency gains are demonstrated.

The good news is that CMS has started to do this with their Comprehensive Primary Care Classic program and as of 2017, Comprehensive Primary Care Plus. If private health insurance plans adopt these CMS policies and state legislatures develop supportive environments RNs will be playing a greatly expanded primary care clinical role in the future.

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