Registered Nurses in Primary Care: What Will They Do?

A few years ago, as I sat on a clinical care board, I was struck by the fact that our medical and executive colleagues had gotten the message about primary care advanced practice registered nurses (APRNs). Yes, they said, the APRNs could manage the clinics related to basic diabetes care and hypertension. That was the good news—our colleagues recognized what those of us who hold the APRN credential could do. Of course, the bad news is that for a lot of the standard care in those two areas, much of the care could be managed by RNs without advanced preparation. Each time I mentioned that idea, I sensed that the idea of almost 4 million nurses being able to manage a patient care issue was more than many could tolerate.

That scenario brings us to the June 2016 Josiah Macy Jr. Foundation report related to RNs. The Foundation’s conference on RNs in primary care acknowledges that RNs have been woefully underused. Some of the specific populations RNs have successfully managed relate to “diabetes, hypertension, chronic obstructive pulmonary disease, substance abuse, and mental health” (Josiah Macy Jr. Foundation, 2016, p. 2). Add to that the transitional care, patient education, care planning, and many other aspects that have been under- or unaddressed in primary care, and it is easy to see what a revolution could occur in health care if we unleashed the talent of RNs to function to their full capacity in primary care. Taking this approach would allow APRNs to manage more complex patients and physicians to address the highly complex patients we know exist in every community. In addition to the challenge of the current role (often focused on triage) and the institutional practices of limiting what RNs can do by licensure, one of the biggest stumbling blocks to this transformation rests with...yes, the insurance industry. We can pay for amputation of the foot of a person with diabetes, but we don’t pay for the ongoing “living with the disease” management that might prevent the need for amputation in the first place. Many services are covered, yet gaps exist that need to be addressed. In the traditional model, a person with hypertension is given medication to lower blood pressure and a brochure about weight control and stress, among other services. If that strategy doesn’t work, the medication is changed.

Dr. George Thibault, President of the Macy Foundation, said, “We simply can’t meet the primary care needs of the nation unless registered nurses are part of the solution, and we must prepare them appropriately and then use them for this role” (Josiah Macy Jr. Foundation, 2016, p. 2). That is where those of us in continuing education have to rise to the challenge. It isn’t sufficient to rely on schools of nursing to refocus their educational and clinical efforts. That approach would take a generation to be where we need to be now. We, too, must address the issues in our clinical settings. What do nurses need to be able to challenge the system to function to their full scope? What do they need in order to refocus from acute care and triage to chronic care and care management? And once we clarify what we need to do for nursing, how do we articulate with the other professions to be sure that the person at the center of care is the one in need of care?

Of course, one of the challenges we face ourselves is who among us is well-prepared in primary care to lead the rest of us to where we need to be? This is a huge challenge that faces us, and the lack of reimbursement for such services is a big blocking factor. However, should we take this on, we will transform not only how we deliver care, but also the quality of care, and thus the quality of life, to people who experience such care.

REFERENCE