The Emerging Primary Care Workforce: Preliminary Observations From the Primary Care Team: Learning From Effective Ambulatory Practices Project

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Abstract

Many primary care practices are changing the roles played by the members of their health care teams. The purpose of this article is to describe some of these new roles, using the authors' preliminary observations from 25 site visits to high-performing primary care practices across the United States in 2012–2013. These sites visits, to practices using their workforce creatively, were part of the Robert Wood Johnson Foundation–funded initiative, The Primary Care Team: Learning From Effective Ambulatory Practices.

Examples of these new roles that the authors observed on their site visits include medical assistants reviewing patient records before visits to identify care gaps, ordering and administering immunizations using protocols, making outreach calls to patients, leading team huddles, and coaching patients to set self-management goals. The registered nurse role has evolved from an emphasis on triage to a focus on uncomplicated acute care, chronic care management, and hospital-to-home transitions. Behavioral health providers (licensed clinical social workers, psychologists, or licensed counselors) were colocated and integrated within practices and were readily available for immediate consults and brief interventions. Physicians have shifted from lone to shared responsibility for patient panels, with other team members empowered to provide significant portions of chronic and preventive care.

An innovative team-based primary care workforce is emerging. Spreading and sustaining these changes will require training both health professionals and nonprofessionals in new ways. Without clinical experiences that model this new team-based care and role models who practice it, trainees will not be prepared to practice as a team.

The delivery of high-value primary care is essential to improving the health of all Americans. However, our primary care system is plagued by problems related to access, continuity of care, inconsistent quality, lack of patient-centeredness, and physician burnout.[1] Over the past several years, in response to national initiatives, such as the patient-centered medical home and the Affordable Care Act, many primary care sites have developed innovative approaches to address these problems.[2] These new approaches require front-line primary care clinicians, staff, and leaders to reexamine traditional roles and responsibilities, create teams with shared responsibility and accountability, and retrain clinicians and staff for these new roles. They also require closer engagement with patients and families and the larger community where such practices are located.

To qualitatively study this process of primary care workforce transformation, in 2012, the Robert Wood Johnson Foundation (RWJF) funded a multiyear initiative—The Primary Care Team: Learning From Effective Ambulatory Practices (LEAP).[3] The LEAP project was designed to identify, study, and engage exemplar primary care practices from across the United States that are using their workforce creatively. The purpose of this article is to report our initial observations from our LEAP site visits, highlighting the changing roles and responsibilities of clinicians and staff, and to discuss the implications of those observations for primary care workforce education and development.

In this article, *clinician* refers to physicians, nurse practitioners (NPs), and physician assistants (PAs). *Professional staff* includes registered nurses (RNs), licensed practical nurses (LPNs), pharmacists, behavioral health providers, and social workers. *Nonprofessional staff* refers to medical assistants (MAs), front office staff, and newer personnel categories, such as community health workers and patient navigators.

About the LEAP Project

We identified the exemplar sites to visit through an extensive literature review and a modified snowball interview technique in which we solicited recommendations from front-line clinicians, managers, and experts across the country. More than 300 practices were nominated, and we reviewed descriptive material describing each. To identify workforce innovations, leaders from 154 practices participated in a detailed telephone interview. A national advisory committee then reviewed the interview results and practice performance data and narrowed the cohort to 30 practices in 20 states. These 30 practices represented a variety of settings, practice configurations, sizes, and geographic locations, including private practices, large health systems, and community health centers. As of August 2013, we have visited 25 of the 30

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practices to observe workforce changes; understand how these changes were made; learn the effects of these changes on physicians, other team members, and the patient experience; and collect tools that might be used by other practices. A three-member team consisting of a clinical expert, qualitative researcher, and research assistant conducted each site visit. They spent three full days in the practice, engaging in a wide variety of data collection activities, including conducting in-depth interviews, observing meetings, shadowing staff and patients, collecting photo documentation, and completing an online survey. In this article, we report our observations from the 25 site visits we have conducted so far, and we agree on the descriptions provided.

Changing Roles in Primary Care

Many different health professional and staff roles are represented in the practices we visited. For example, many practices employ NPs, PAs, RNs, LPNs, pharmacists, behavioral health providers, as well as MAs, community health workers, care coordinators (not always health professionals), and others in a formal or informal team structure. Here we highlight four of the workforce roles that we believe have changed the most—MAs, RNs, MDs, and behavioral health providers—and we briefly describe new roles that are appearing in primary care.

Medical assistants

MAs are ubiquitous in primary care,[4] and all the practices we visited are expanding MAs' responsibilities. In some practices, MAs and LPNs play similar roles. A number of practices also have given MAs the task of panel management: identifying and addressing gaps in the periodic chronic and preventive care service recommended by clinical practice guidelines.[5] MAs complete such tasks by performing previsit chart review one or two days before the clinician's visit and flagging overdue services, or care gaps, that they or clinicians then can address during the visit. When MAs perform previsit chart review, they then are able to lead morning team huddles because they have up-to-date information on the patients scheduled for that day. As practices can generate lists of patients with care gaps, separate from scheduled visits, MAs then can proactively contact those patients, by sending outreach letters or making outreach calls to inform patients of care gaps.

In addition, some practices have trained and empowered MAs to act as health coaches, teaching patients about their chronic conditions, assisting patients with practicing healthy behaviors, assessing medication adherence, and encouraging patients to be active partners in their care.[6] Some practices have developed extensive training programs for MAs that cover chronic disease management, motivational interviewing, and health coaching. In these roles, MAs are supported by a career ladder with levels ranging from patient care assistant to health coach to floor coordinator. Despite these different roles, the path to becoming an MA is highly varied, ranging from an 8-month training in a proprietary school to an 18-month community college program to completely on-the-job training.[7]

Transferring panel management responsibilities from clinicians to nonprofessional team members, such as MAs, has been shown to improve rates of colorectal cancer screening and other preventive services.[8,9] Health coaching performed by MAs also has been shown to improve outcomes for patients with diabetes and patients with depression compared with those not receiving such care.[10,11]

Many practices are eager for MAs and other staff to perform at the highest level consistent with their training and scope of practice, which in many states is the ability to perform any clinical task under a physician's supervision.[12] In some practices we visited and in some states in general, this scope of practice means that MAs have more flexibility than RNs and LPNs. As a result, some LEAP practices have found that maximizing the roles of MAs requires higher staffing levels but that the costs of doing so may be offset by increases in clinicians' productivity and reimbursement.

The Center for Excellence in Primary Care at the University of California, San Francisco, School of Medicine has trained hundreds of MAs in health coaching and panel management in safety-net practices through two California community college programs. Integrating these topics into current MA training programs could create a ready supply of MAs prepared to assume these roles in primary care practices.[13] However, no nationally recognized curriculum exists for training MAs to assume these roles.

Advanced practice clinicians and RNs

In most practices we visited, NPs as well as PAs are practicing as full primary care clinicians, managing a panel of patients and practicing similar roles under analogous guidelines to physicians. This role of NPs and PAs as primary care clinicians is well established—the new normal in virtually every practice we visited.

The role of RNs in primary care, however, is undergoing significant change. After decades during which RNs disappeared from most primary care practices, our site visits revealed multiple innovative practices in which RNs are deeply involved in the care, treatment, and management of patients. These new roles differ sharply from the traditional emphasis on RNs triaging patient phone calls and drop-ins. As MAs assume greater responsibility for panel management and administering immunizations, RNs then can assume additional patient care responsibilities. Most often, RNs take on the role of care manager, assuming major responsibility for subsets of panels of patients with chronic conditions, such as diabetes, hypertension, and asthma. These RN care managers meet with patients, provide intensive education and support, follow up by phone and/or e-mail, and, in some sites, refill medications by protocol. They also follow up on patients who are discharged from the hospital and coordinate complex specialty care.[14]

Another role that RNs have assumed is that of complex care manager, in which they assist clinicians with patients who have multiple diagnoses, polypharmacy, and high use of hospital and emergency department services. In one practice, for example, each RN care manager supports an average of four primary care clinicians. Patients are referred to the care manager at the clinician visit, from quality improvement reports identifying patients not at target for chronic disease control, and from health-plan-generated use reports. Then, the RN complex care manager performs detailed assessments, creates care plans, makes home visits, and discusses difficult problems with the team.

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Although most of the practices we visited have fully implemented these new roles for RNs, other practices may be limited in expanding RNs' roles because of the difficulty in recruiting RNs with adequate training in managing acute and chronic conditions in ambulatory care settings and the lack of readily available "off the shelf" protocols for such training. In addition, practices in states that prohibit MAs from administering medications, including vaccines, rely on RNs for this high-volume, time-consuming function.

Studies show that teams including RNs are effective in improving chronic disease outcomes, for example, in diabetes.[15] Trained RNs also can independently manage uncomplicated acute illnesses, such as respiratory and urinary tract infections and musculoskeletal problems, to the same success as physicians.[16] Finally, RN complex care managers have been associated with improved care and reduced costs.[17]

Physicians

In virtually every practice we visited, physicians are shifting from lone to shared responsibility for a panel of patients, with other team members empowered to provide significant portions of chronic and preventive care.[18] In practices where MAs have been trained as panel managers, physicians are gradually coming to trust that the MAs would carry out that task with persistence and quality. Sharing the health coaching role with MAs or RNs requires an even greater level of physician trust because health coaching constitutes a major portion of chronic disease management. Distributing patient care responsibilities to other team members, based on their expertise and training, frees up physicians and other clinicians to see more patients and more effectively manage a subset of complex patients needing their unique expertise. Training is critical to empowering other team members to take on these responsibilities, sharing patient care with physicians.

Unlike more traditional practices, many practices we visited provide an internal training program for all team members. Often, they devote a defined time per week or month to such training, including interactive discussions, exams, competency checks, quality review, and ongoing mentoring. Devoting practice time to this training is a big investment because it occurs during revenue-generating practice hours.

Once physicians see that MAs are trained and have passed competency tests, they are more willing to trust and delegate responsibilities to them and to other team members. Building physicians' trust in their team members is essential to making the culture shift from the physician-centric model of care delivery to a team model in which the physician may be the clinical team leader but all team members are focused on meeting the needs of patients.[19]

Behavioral health providers

The need to integrate behavioral health into primary care has been documented for years.[20] The RWJF initiative, Depression in Primary Care: Linking Clinical and Systems Strategies, recommended such integration based on the chronic care model.[21] In many practices we visited, behavioral health providers, such as psychiatric NPs, licensed clinical social workers, psychologists, or licensed counselors, are fully colocated and integrated within the practice, readily available for immediate consults and brief treatment. This model is a marked departure from the relatively recent past when patients were required to seek behavioral health services through referrals to other locations, with information rarely shared between providers.

Behavioral health providers in most practices we visited actively participate in clinical care and practice improvement and regularly consult with and are consulted by clinicians, RNs, MAs, and others. They often focus on short-term cognitive behavioral therapy. This approach eliminates delays in moving patients between primary care and behavioral health care practices. Patients with long-term needs or complex psychiatric medication issues are referred to specialized behavioral health services. In most practices we visited, the electronic health record (EHR) is integrated and available to all team members, promoting care coordination and information sharing between providers and staff. Research has shown that integrating behavioral health care into primary care practices, as these practices have done, improves care and allows physicians to spend more time with complex patients needing their unique expertise.[20]

New roles

Some practices we visited reinvented the roles traditionally held by MAs and receptionists that focus on customer service, access and flow, patient advocacy, and community engagement. For example, patient advocates and outreach workers conduct health fairs and screenings in the community, actively engage patients in prevention activities, and connect them to resources outside the primary care practice. Patient navigators help patients to access referral services. New job titles include clinical flow coordinator, patient access coordinator, and referral coordinator, which is a critical function for ensuring smooth care coordination with specialty and ancillary services. These new roles also offer MAs and receptionists opportunities to advance.

Next, many practices we visited hire staff with expertise in information technology and quality improvement and have a sophisticated approach to quality measurement and practice redesign. Some of these staff are alumni of quality improvement learning collaboratives. Bright, ambitious, well-educated young people with technology skills, but no formal health care training, increasingly are applying for such staff positions in primary care. In two practices, such skilled staff ensure that the practice is taking advantage of the full functionality of the EHR. In other practices, the quality improvement staff participate in team huddles to better understand how information technology interacts with clinical workflows.

Implications for Preparing the Emerging Primary Care Workforce

In many primary care practices across the United States, a new workforce is emerging. Our site visits indicated that team-based, population-oriented practice does not come naturally. Older, more experienced health professionals were not the only ones having difficulty adjusting to newer models of care delivery. Recent medical and nursing graduates also struggled because they were trained in traditional practice settings. Our preliminary observations from the 25 LEAP site visits we conducted have

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significant implications for preparing the workforce to enter and lead innovative primary care practices.

Observations from our site visits demonstrate that a new primary care workforce is emerging in many practices. This new workforce differs from the traditional one in several important ways. First, it is not simply a professional workforce but an amalgam of professionals and nonprofessionals. The nonprofessional MAs who are ubiquitous in primary care are taking on significant new roles and responsibilities. Other nonprofessional staff, such as receptionists, clerks, and community health workers, are more engaged than before with patients, patient care, and the clinical team. Second, clinicians, especially physicians, have had to shed the belief inculcated during training that the conscientious clinician has to do everything. Rather, clinicians are learning to trust their teammates. Third, RNs increasingly are using their clinical training and skills to help manage the sickest patients. Finally, the emerging primary care workforce is centered on the team and the patient rather than on the physician and the office, with teams collectively being responsible for the health of their patient panel.

However, current academic training programs for primary care team members do not meet the needs of the emerging team-oriented primary care workforce. Medical education favors the lone physician model rather than the team-based model.[18,22] The training of nurses and MAs also does not prepare them for new team roles.[7,23,24] In addition, the pace of change in training programs for professional and nonprofessional primary care providers may not be fast enough to train sufficient numbers of staff to meet the needs of an evolving primary care sector. Also, many, if not most, health professional faculty do not practice team-based primary care, and therefore they are not well prepared to teach about such models of care delivery.[25,26] Moreover, interprofessional education is not yet widespread enough to consistently ensure that professionals gain the skills needed to work in teams with nonprofessional staff.

Finally, too few innovative primary care practices, like the LEAP sites we visited, exist to serve as role models for training the new workforce. However, three trends provide some hope for the future despite their limited use now—the federal grant program for physician training in teaching health centers, NP primary care residency training, and some primary care teaching sites beginning to model team-based care for medical and nursing students and medical residents.[27,28] However, unless many more health professional students and nonprofessional trainees take part in explicit clinical experiences with others in team-based care during their formative training years and see their role models practicing in this way, they likely will not be prepared to practice in a team-based care model.[29]

Going Forward

Our site visits to innovative primary care practices demonstrated that a team-based primary care workforce is emerging. To ensure an adequate supply of this new workforce will require that learners train in practices in which all team members, including nonprofessional staff, have adopted this team-based culture and are well prepared to contribute to patient care individually and as part of a team. A key role for projects like LEAP is to stimulate a national conversation on education reforms needed to better prepare both health professionals and staff to assume these new roles.

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