The New Medical Workforce

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Goals

• Discuss the increased demand for primary care services and other workforce issues to improve the supply of primary care providers who are not physicians
• Discuss issues around scope of practice and regulatory practices that limit optimal use of these providers
• Examine innovative models to provide primary care
PRIMARY CARE
IOM, 1996

Primary Care is the provision of **INTEGRATED, ACCESSIBLE** health care services by clinicians who are **ACCOUNTABLE** for addressing a large majority of personal health care needs, developing a **SUSTAINED PARTNERSHIP** with patients, and practicing in the context of **FAMILY** and **COMMUNITY**.

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**Who is Providing Primary Care?**
(Pohl, 2013)

<table>
<thead>
<tr>
<th>Total (2013 data)</th>
<th>Percent primary care by selected clinicians*</th>
<th># Practicing primary care</th>
</tr>
</thead>
</table>
| Physicians
(878,194)
Federation of State Medical Boards Data | 33% | 208,807 (2010)
289,804 (2013) |
| NPs
180,233
93,721-108,000 (2013) |
| PAs
86,500
37,541 (2013) |
| Total 1,144,927 | | 294,834 (2010)
421,070 + (2013) |

*([AHRQ](https://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html))
**Geographic Distribution of Health Care Professionals in Primary Care, 2010**


<table>
<thead>
<tr>
<th>Geography</th>
<th>NP</th>
<th>PA</th>
<th>Family physicians</th>
<th>Gen Internal Med</th>
<th>General Peds</th>
<th>US Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>72.2%</td>
<td>75.1%</td>
<td>77.5%</td>
<td>89.8%</td>
<td>91.2%</td>
<td>80%</td>
</tr>
<tr>
<td>Large Rural</td>
<td>11.0%</td>
<td>11.7%</td>
<td>11.1%</td>
<td>6.7%</td>
<td>6.2%</td>
<td>10%</td>
</tr>
<tr>
<td>Small Rural</td>
<td>7.7%</td>
<td>6.9%</td>
<td>7.2%</td>
<td>2.4%</td>
<td>1.8%</td>
<td>5%</td>
</tr>
<tr>
<td>Remote Rural/Frontier</td>
<td>9.1%</td>
<td>6.3%</td>
<td>4.2%</td>
<td>1.1%</td>
<td>0.8%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**2014 Physician Match Data**


- Family Medicine match by U.S. medical students: 1,416 (an increase of 62 from 2013)
- General Internal Medicine Primary Care matches by U.S. medical students: 202 (an increase of 2 from 2013).
- Primary Care Pediatrics match by U.S. medical students: 34 (an increase of 4 from 2013)
- Internal Medicine Pediatrics match by U.S. medical students: 284 (a loss of 28 from 2013)

Total of 1,923 U.S. medical school graduates matched to primary care residency programs
Including international graduates, 3,759 primary care matches

Pohl, 2013
2014 Primary Care NP Workforce Data
Based on 2013 NP Graduation Rates*

- **14,411** graduates from all NP programs in 2013
- **13,645** prepared in primary care roles
  - An increase of 1,881 from 2012
  - Enrollment rates continue to grow
  - Currently a total of about 180,000 NPs nationally

*American Association of Colleges of Nursing (AACN) and National Organization of Nurse Practitioner Faculties (NONPF)(2014). Enrollment & Graduation Annual survey.

Specific Primary Care NP Rates

- Family NP: 9,623
- Adult NP: 953
- Adult/Gero & Gero NP: 1,669
- Peds NP: 821
- Women’s Health: 421
- Dual Track: 158

Physician Workforce Projections (AAMC, 2010)

*Projected Supply and Demand, Physicians, 2008-2020 (ALL SPECIALTIES)*

[Graph showing the projected supply and demand of physicians from 2010 to 2020]

Source: [https://www.aamc.org/newsroom/keyissues/physician_workforce/](https://www.aamc.org/newsroom/keyissues/physician_workforce/)
Workforce Projections for Pharmacists

<table>
<thead>
<tr>
<th>Service Type</th>
<th>No. Pharmacists Employed in 2001</th>
<th>No Pharmacists Needed in 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order Fulfillment</td>
<td>136,400</td>
<td>100,000</td>
</tr>
<tr>
<td>Primary Services</td>
<td>30,000</td>
<td>165,000</td>
</tr>
<tr>
<td>Secondary and tertiary services</td>
<td>18,000</td>
<td>130,000</td>
</tr>
<tr>
<td>Indirect and Other</td>
<td>12,300</td>
<td>22,000</td>
</tr>
<tr>
<td>Total</td>
<td>196,700</td>
<td>417,000</td>
</tr>
</tbody>
</table>


The Problem

- Medical school graduates are not choosing primary care specialties to an increased degree.
- The ACA has improved access to care for many Americans thus more primary care is needed.

What is the alternative?

This is where expanded scope of practice for nurses and other health professions comes in.
Initiative on the Future of Nursing

Recommendations for an action-oriented blueprint for the future of nursing

Four Key Messages

#1. Nurses should be able to practice to the full extent of their education and training
#2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression
#3. Nurses should be full partners with physicians and others in redesigning U.S. health care
#4. Effective workforce planning and policy-making require better data collection and an information infrastructure
The State Practice Environment for NPs

- 22 states and the District of Columbia allow independent practice with some prescriptive limits
  https://www.ncsbn.org/2567.htm
- 18 states and the District of Columbia allow NPs to practice fully under their own license (full plenary authority) including prescriptive authority
  - NY, CT just passed legislation
  - Nebraska passed legislation and governor vetoed it.
- At least 12 states are considered most restrictive including MA., Mich., Calif., Fla., VA.

2013 Nurse Practitioner State Practice Environment

Full Practice
Reduced Practice
Restricted Practice

Changes in Healthcare Professions’ Scope of Practice: Legislative Considerations (NCSBN, ASWB, FSBPT, FSMB, NABP, NBCOT, 2006)

- Professional scopes of practice have evolved
- Overlap among scopes of practice is common.

“Overlap among professions is necessary. No one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within the practice that makes any particular profession unique. Simply because a skill or activity is within one profession’s skill set does not mean another profession cannot and should not include it in its own scope of practice” (p. 9).

Critical factors in decision-making process for regulatory boards regarding scopes of practice

- Historical basis for the profession, especially the evolution of the profession advocating a scope of practice change
- Relationship of education and training of practitioners to scope of practice
- Evidence related to how the new or revised scope of practice benefits the public
- The capacity of the regulatory agency involved to effectively manage modifications to scope of practice changes.

“Overlapping scopes of practice are a reality in a rapidly changing healthcare environment. The criteria related to who is qualified to perform functions safely without risk of harm to the public are the only justifiable conditions for defining scopes of practice.” (p. 17)
The Problem

• Even if all NPs and PAs were allowed to practice independently, there would still not be enough primary care providers to go around.
• No major problems have been reported in the states that allow independent practice so what is the problem?

What are the market forces at play?

• New models for primary care practice are evolving along with expansion in scope of practice for health professionals.
• How can we foster innovation in the market?

Policy Perspectives: Competition Advocacy and the Regulation of Advanced Practice Nurses, FTC, March 2014.

Potential harms from APRN Physician supervision requirements:
– Exacerbate well documented provider shortages
– Increase health care costs and prices
– Constrain innovation in health care delivery models
– Mandated collaboration agreements are not needed to achieve the benefits of Physician /APRN coordination of care
– Competition Advocacy Comments issued for Massachusetts, Connecticut, West Virginia, Louisiana, Kentucky, Texas, and Florida.
“...rigid ‘collaborative practice agreement’ requirements may be inconsistent with a truly collaborative and team-based approach to health care. Such requirements can impede collaborative care rather than foster it, because they limit what health care professionals and providers can do to adapt to varied health care demands and constrain provider innovation in team-based care.” (FTC, 2014, p.20)

Disruptive Innovations:
New Models of Care

Retail Clinics
Nurse Managed Clinics
Use of traditional professionals in a new way
– PharmD’s as part of the primary care team
– OTD/PTDs with increased responsibility for care within the health care team
– Community Health Workers as team members
– Use of RNs in Primary care to provide care coordination, work more closely with PCPs and in new team configurations, group visits etc.

Is patient engagement a disruptive Innovation??
Conclusions

- As the ACA is fully implemented the need will increase for primary care providers.
- New and existing models are needed to meet these needs.
- Team care will be a key component of these models but will work best if each professional on the team is able to work to the top of their license.
- “Independent” practice does not preclude collaboration but instead is enhanced by it.
- Patient/family centered care as well as patient engagement will lead to highly knowledgeable and involved consumers who will advocate for the care that best meets their needs.

References


American Association of Colleges of Nursing (AACN) and National Organization of Nurse Practitioner Faculties (NONPF). Enrollment & Graduation Annual Survey., 2014.


National Council of State Boards of Nursing (NCSBN). (2014). APRNs in the US. Available at: https://www.ncsbn.org/2567.htm


References


