

Position Statement



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Primary Care

Vision, Roles and Opportunities

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The purpose of this document is to:

1. articulate the College and Association of Registered Nurses of Alberta (CARNA) vision of primary care
2. describe the roles and responsibilities of registered nurses (RNs) and nurse practitioners (NPs) as part of the interprofessional team within a reformed and strengthened primary care system
3. identify the issues that must be addressed in order to achieve further reform of primary care

Introduction

Centered in the community and the key point of access for Albertans, primary care serves as the foundation of the health system. **Primary care** refers to the first contact people have with the health system to seek services for diagnosis, treatment and follow up for a specific health problem, or to access routine screening such as an annual checkup (CARNA, 2008).

Strengthening primary care has become a focus of health care reform in Alberta and beyond, since most chronic illness can be managed at the primary care level. Thirty percent of Alberta patients have chronic illness and are responsible for sixty percent of health care costs (Health Quality Council of Alberta, 2009). Health promotion/disease prevention, screening, identification of risk and management of chronic illness can prevent or minimize its impact. In addition to the management of chronic illness, primary care also addresses health care needs related to maternal/child health, mental health and addictions, and rehabilitation.

CARNA Vision of Primary Care

Patient-Centered Care

- Patients are the centre of care within a primary care system.
- Patient-centered care means patients are partners who actively and effectively participate in decision-making and the development of their care plans at the level they choose.

- Patients are respected and valued - providers listen to the patient, honor patient choices and preferences, and understand the patient's beliefs, values and circumstances
- Patients seamlessly navigate from one part of the system to another through effective case management and coordination of care.
- Patients are confident in managing their own care and seek services as needed due to the support received from the interprofessional team.
- Patients receive complete, accurate and unbiased information such that they are able to make choices for their care and treatment.
- Patients can access their health records and are able to add information to them.

Access to Services

- Patients have timely access to services when needed. There are no barriers or unnecessary steps in seeing the right provider.
- Interprofessional teams share decision-making to meet the health goals of their patients. The lead provider for an individual patient depends on the needs of the patient and might be the physiotherapist, pharmacist, physician, nurse practitioner, dietitian or registered nurse.
- Communication and referral moves easily between members of the health care team and adjustments to the plan of care can be made according to the changing needs of the patient.
- Community resources are accessed as needed and case management ensures smooth navigation through the health system.

System Management

- Evidence-informed programs and services are developed, based on appropriate data, in response to local needs. Key performance indicators are measured and monitored and the information is used to continuously improve services.
- Creativity and innovation are encouraged and supported in the development of primary care services.
- Healthcare providers are engaged and positive about the opportunities to work together to meet client needs.

- The electronic health and medical record has been implemented so that all providers and parts of the system are effectively integrated.

Appropriate Funding for Primary Care

- Funding mechanisms incent comprehensiveness, access to services and optimal use of the health care team and resources.
- Additional needs-based funding is provided for patient populations that are complex, at additional risk and require more resources to meet their needs.

Patient Commitment

- Patients are committed to achieving optimal health status through active participation in care planning, care implementation and monitoring of their own health.
- Patient and health care provider satisfaction is high.

Expected Outcomes

Strengthening of primary care will result in lower overall health care costs and positive patient outcomes. While tertiary care will always be necessary for some patients, the need for tertiary services will decrease as health care needs are increasingly being met at the primary care level through:

- health promotion/disease prevention and risk reduction programs
- screening
- care coordination and case management
- appropriate use of community resources
- improved chronic disease management
- patient self-management and self-efficacy

Registered nurses believe that such a vision can be achieved. The contributions of RNs and NPs to this vision are outlined below.

The Role of the RN and NP in Primary Care

The educational preparation and knowledge and skills of RNs and NPs provide them with an opportunity to make important contributions to health care renewal and more effective service delivery within primary care. Some of the roles and responsibilities of RNs and NPs within primary care are outlined below.

Registered Nurses

Care of individual patients

Within primary care registered nurses provide a number of services independently, including:

- triage and assessment of clients
- administration of allergy treatment
- teaching with respect to healthy lifestyles
- smoking cessation programs
- development and management of anti coagulation therapy through the use of an INR protocol
- women's wellness programs including breast and cervical screening, prenatal and well-baby care
- arthritis self-management
- palliative care
- heart health
- weight reduction clinics
- health promotion, disease prevention, and risk reduction programs
- chronic disease management

In many primary care settings, the RNs will manage a group or panel of patients who have a specific disease entity. Their responsibilities include assessing test results, referral and follow-up to assist with problem-solving and ensuring regular monitoring of the patient condition.

Coordination of care and case management

Not all services needed by patients are provided within the primary care setting. Many patients have diverse social as well as health care needs. In addition the patient may have episodic treatment in a hospital or reside in long-term care or an assisted living facility. Coordination of care and case management with community resources, specialists, home care, public health, other facilities and family members is essential for effective chronic disease management and to address the needs of maternal/child, mental health and addictions or rehabilitation patients.

The holistic and generalist nature of RN education and practice provides a solid foundation for:

- assessment of patients for additional resources related to social or health care needs
- identification of community or other resources available
- patient advocacy when needed
- implementation of care
- coordination of care and/or case management to connect patients to needed community resources
- navigation of the health system where care requirements are complex and involve a number of different services or specialties
- follow up to evaluate care received and ongoing health care needs with adjustments to the care plan as needed

Health promotion, disease prevention and support for self management

Patients accessing services within a primary care setting see their health care providers for short visits to meet immediate needs and review progress, but must live with and manage their condition on a daily basis. Patients increasingly want to be full participants in planning their own care. There has been a shift from patients passively accepting information and decisions from health care providers to actively searching the internet and other sources for information related to their health problem or diagnosis.

Informed and appropriate support by RNs can enable patients to take control of their own health through:

- providing information and teaching so that patients have a solid understanding of their condition and treatment

- developing an action plan with patients to prevent further deterioration, maintain or improve their present health, or minimize any treatment side effects
- supporting and coaching patients in the development of coping strategies, self advocacy, and accessing community resources
- providing guidance on reliable and appropriate health information resources
- identifying criteria patients can use to determine when further assessment by a health care provider is needed
- participating in group visits in partnership with other members of the interprofessional team
- coaching patients on the most appropriate use of health services

Program development

Within primary care, there are many opportunities for registered nurses to develop programs and services in response to patient needs. Programs arise from the aggregate needs of the patient group and will be different from one geographical area to another. In a primary care setting with a large population of seniors, chronic disease management services and strategies may be prominent while a primary care setting in a new urban development in the suburbs may have more of an emphasis on maternal/child services.

Management of chronic illness

“For those examining the effectiveness of an interdisciplinary chronic disease management model, a key component was the use of a single person (usually a registered nurse) to act as the first point of contact and coordinator of interactions with other providers and services. Several projects found that this model was effective in providing much needed support to complex chronic disease patients by a range of interdisciplinary members” (Health Canada, 2010b).

In addition to coordination and case management with respect to chronic illness, the RN can provide recommended preventive management and surveillance including:

- monitoring of the patient condition
- identification of the need for referral to the physician or NP
- engaging in patient teaching
- follow up with the patient in responding to fluctuation of laboratory values (e.g. INR or blood sugar values)

- assistance with problem solving to address the day to day challenges of living with a chronic illness
- monitoring and referral if necessary for associated depression that can occur with chronic illness

Liaison with hospital services

Continuity of care is necessary in the transition from admission to and discharge from an inpatient unit back to primary care. Partnerships using RNs as liaisons link acute care programs and services with the primary care team and community resources. This can be very effective in reducing readmission to hospital due to complications or relapse.

Administrative management in Primary Care

Many registered nurses have valuable experience as managers and administrators within the health system and can contribute their expertise to the management of primary care programs. A broad perspective is needed to coordinate, supervise, monitor and evaluate the provision of health services as well as to manage, administer and allocate resources.

RNs successfully work as change facilitators in primary care settings where their responsibility is to look at system redesign and processes to increase efficiency within the setting itself. An understanding of the holistic care of clients, the health system as a whole and community resources enables the initiation of improved linkages and enhanced communication.

Nurse Practitioners

Nurse Practitioners are first and foremost registered nurses. Their scope of practice includes that of the registered nurse. They are autonomous health care providers with advanced education, generally at a graduate level, who provide a full range of comprehensive health services to the public.

NPs providing treatment and care

The traditional model of a physician as “medical expert” and the RN as provider who coordinates care, supports, teaches and monitors the client has been an effective approach to providing health services including primary care. The addition of the NP to the collaborative practice team provides for greater flexibility, support and enhancement of the provision of services. This approach to care has proven successful in a variety of settings, including primary care.

The scope of practice of NPs overlaps with that of physicians because NPs are educated and legally authorized to make differential medical diagnoses, order and interpret tests and prescribe Schedule 1 medications. NPs working in primary care can:

- carry an independent caseload, facilitating greater patient access to care
- meet the unique care needs of a population (e.g. women's health, elder care) and address gaps in health services (e.g. home visits, support to long term care facilities)
- address the needs of complex chronic disease patients
- make referrals and consult with specialists and other services
- critically evaluate best evidence and integrate various clinical practice guidelines to make appropriate clinical decisions

NP system leadership

NPs' nursing expertise and additional scope of practice provide them with the ability to:

- design service delivery models
- participate in, promote or initiate research
- create programs to meet specific health promotion/disease prevention care needs of a population, develop practice guidelines and standards, initiate quality assurance programs
- evaluate care, services and outcomes

Moving Primary Care Forward

Primary care services are provided in many settings such as physician offices, outpatient clinics and community agencies, including those that provide services to vulnerable populations. The initiation of primary care networks (PCNs) in Alberta in 2003 was one strategy intended to improve health care organization and delivery of primary care services. A PCN is a network of family physicians and other health care providers such as registered nurses, nurse practitioners, dietitians, and pharmacists who work together to provide primary care services. PCNs were established through the Primary Care

Initiative (PCI) under the Physician Master agreement (2003)¹ and are based on a partnership between the Alberta Medical Association (AMA), Alberta Health Services (AHS) and Alberta Health and Wellness (AH&W). The key objectives of the PCI are to:

- increase the proportion of residents with ready access to primary care
- provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services
- increase the emphasis on health promotion, disease and injury prevention, care of the medically complex patient and care of patients with chronic disease
- improve coordination and integration with other health care services including secondary, tertiary and long term care through specialty care linkages to primary care
- facilitate the greater use of multi-disciplinary teams to provide comprehensive primary care

(Alberta Health and Wellness, Alberta Medical Association, & Regional Health Authorities, 2003)

As Alberta moves forward in reform of the health system, the following issues must be addressed:

1. Primary care must be integrated with the rest of the system for the benefit of all Albertans.

The partnership of AHS, AMA and AH&W was an important beginning in the reform of primary care. Since the physician master agreement was signed in 2003 to include provisions for PCNs, much has changed in Alberta – particularly the dissolution of the regional health authorities and creation of a single health services delivery entity for the province. This amalgamation did not include integration of primary care services. The restructuring that has taken place thus far needs to be evaluated to determine gaps, duplication of services and the most effective use of health human resources. The development of a seamless health system requires further work to integrate primary care with the rest of the system in an intentional manner.

¹ The Master Agreement defines the relationship between AMA, government and AHS. It also provides for compensation and benefits for physician services and the PCI agreement.

2. Dedicated funding for team development and support of collaborative practice must be established.

The benefits of interprofessional care and the development of a team based approach to care are well known and documented (Nolte, J & Tremblay, M, 2005). Collaborative practice is an interprofessional process for communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client care provided (Health Canada, 2004). Trust and respect among health professions is at the heart of interprofessional collaboration in primary care. Each profession brings its own set of knowledge and skills - the result of education, training and experience - to collaborative care. A collegial environment that supports shared decision-making, creativity and innovation boosts the capacity of individual professionals, teams and health systems. Commitment to teamwork and collaboration allows health professionals to learn from each other and gain an understanding of the competencies and scope of practice of their peers.

Team development strategies, interprofessional education and facilitation of change management need to be initiated in primary care settings. It is not adequate to simply co-locate health care professionals or form networks where providers are in different locations – support is needed in order for them to collaborate and function effectively as teams. This support begins with education as students where interprofessional care and effective team functioning are modeled. For those already in the system, support and education related to collaborative practice are needed to move towards the vision for primary care and fully integrate it into practice.

Collaboration occurs not only within the primary care setting but with community partners such as home care and community agencies. They may have similar initiatives to address patient needs. For example, AHS may also have various initiatives to address chronic disease management, as does the primary care setting.

3. Information systems to support collaborative practice and integrate primary care with the rest of the system must be fully implemented.

The electronic health and medical record should be structured to support and make visible the contributions of all team members to patient outcomes. As an example, there are many gaps in the availability of nursing clinical data. This data is necessary for the assessment and evaluation of nursing care. While a number of

systems have been developed, they need to be able to interface throughout the province and across service sectors so that we can move forward.

Traditionally, billing systems have been the means of tracking payment and planning for physician delivery of primary care services. This needs to be replaced with systems that can track the full range of primary care services delivered by the interprofessional team. Data needs and methods of collection should be identified to support evidence-informed decision-making. Key performance indicators need to be identified, measured and monitored.

4. Funding mechanisms that facilitate interprofessional care must be developed.

Funding for teams and compensation for all providers must recognize the unique contributions of each profession. Funding agreements should consider the PCN to be an entity where funding is provided to the PCN for the services that are provided by the team to meet the health needs in a defined population. Individual PCNs need a funding approach based on the needs and risk factors related to the patient population they serve. Expectations and funding allocation for the interprofessional team need to be clearly specified and held as a deliverable. The value of team members needs to be integrated and recognized in funding models that are developed for primary care.

There are issues related to overhead, infrastructure, and payment for services provided by NPs, RNs and other health care providers in primary care settings. Size and location of a PCN can impact on the flexibility and number of services that can be initiated. Adequate physical space and the use of supplies need to be addressed as new members of the team are integrated into primary care settings.

The fee for service payment of physicians where they must “see the whites of the eyes” to receive compensation is a barrier to the development of effective teams and new ways to provide care. It creates a scenario where all costs for the interprofessional team are incremental, new or additional and no substitution benefits are realized. CARNA recommends funding models whereby physicians are compensated via fees or contracts for services they provide and other members of the team are compensated for their roles via public funding that does not flow through the physician compensation route.

Funding models must be patient-centered rather than provider-driven and create incentives for comprehensive care. For the system to be truly patient-centered, the

funding must follow the patient and enable the best choice of provider to meet the patient's needs.

5. Infrastructure to support effective functioning and consistency in primary care organizations must be developed.

All primary care organizations require adequate infrastructure and policy development to support them, including:

- performance management to monitor and evaluate performance and outcomes of the PCN as an entity
- standardization of teams
- reimbursement
- use of technology and procurement
- mechanisms for collaborative planning, integration and implementation with the rest of the health care system
- incentives to support team based practice; and linkages with academic institutions

While these elements need to be examined, the overarching structure should support and facilitate flexibility, autonomy, innovation, creativity and the meeting of local needs, allowing each PCN to be distinct.

In examining infrastructure, two questions are emerging:

- What is the optimum size of a PCN?
- What infrastructure and strategies are needed for effective delivery of services when members of the interprofessional team are co-located vs. being part of a network where offices are dispersed geographically?

Relevant research and business theory may be helpful in resolving these questions.

The issue of patient enrollment should be examined with a view to looking at what incentives encourage patients to commit to a PCN - receiving all of their primary care services there and thus ensuring continuity of care. Patients must be able to see a benefit to enrollment such as increased access to services and improved coordination of care.

Another aspect of infrastructure that needs to be initiated is the development of consistent policy and procedures for primary care settings, particularly as they relate to the provision of nursing services and patient care. Currently, there is a lack of policy directives in PCNs as compared to those in other parts of the health system. Examples include job descriptions to guide the development of roles and responsibilities, documentation guidelines and nursing clinical practice guidelines. Primary care settings are starting to develop these but support is needed to ensure a consistent approach across the province.

6. Governance and leadership of the care team is dependent on the needs of the patient.

The leadership of the care team for a particular patient will be dependent on the needs of the patient, e.g. it may be the physician if there are complex medical needs, the physiotherapist for the patient with needs related to rehabilitation, the pharmacist if there are complex drug interactions in the medication regime or the registered nurse for screening, health promotion/disease prevention or management of the chronic illness.

In both rural and urban areas, there are few physicians taking new patients and demand is high, so timely access to care is an issue. The PCI agreement states that a “Strong patient physician relationship is a fundamental building block for primary care improvement and every Albertan should be encouraged to establish a relationship with a family physician” (Alberta Health and Wellness, Alberta Medical Association, & Regional Health Authorities, 2003, p. 4).

Under the *Health Professions Act* (HPA), it is recognized that there are overlapping scopes of practice. CARNA supports that establishing a strong relationship with a primary care provider is a fundamental building block for improvement of primary care. However, nurse practitioners as well as physicians and other health care providers establish relationships with patients, develop treatment plans and increase access to services. Governance and staffing of primary care organizations should reflect the interprofessional team.

7. Other models to complement PCNs and address underserved populations need to be initiated.

Under the PCI, the Primary Care Initiative Committee approves the letters of intent and business plans in the initiation of a PCN. In meeting the needs of diverse populations and increasing access to care, additional approaches need to be explored in order to facilitate the development of other innovative models. For

example, nurse managed NP/RN stand-alone primary care clinics might be established and affiliated with a PCN. These clinics have been successfully established in other Canadian jurisdictions. (Registered Nurses' Association of Ontario, 2010)

8. A deliberate strategy to attract RNs to the primary care role and integrate the NP into primary care must be developed

A concerted effort must be made to attract RNs to roles within primary care and integrate NPs. They must be able to practice to their full scope of practice if they are to be retained once they are in place. RNs, NPs and other health care providers should be engaged as full partners in the planning and evaluation of primary care services. The strategy must address the transfer of pensions and benefits since it is often the more experienced RNs that are the best suited to the primary care environment.

9. The public must be engaged in reform and renewal of primary care.

Reform and renewal of the primary care system must be patient-centered. As the PCNs and other primary care models are further developed, partnerships with the public need to be formed so that this voice can be heard. Engagement of all stakeholders, including the public, into the planning and implementation of the delivery of services creates shared commitment and facilitates development of the most appropriate and effective primary care services for each community.

Many patients do not realize they belong to a PCN. Formal enrollment and public education is needed so patients understand the kinds of services available for them through the PCN and how to access them.

Conclusion

The driving force behind primary care reform has been the emergence of issues related to chronic illness which can be addressed and managed at the primary care level. Primary care involves seniors health, maternal/child health, mental health and addictions, and rehabilitation. While reform and renewal of primary care will lead to more appropriate care and better outcomes for those living with a chronic illness, it will also have an impact on the health care needs of other populations. Maternal/child, mental health and addiction and rehabilitation patients also have diverse social and health care needs; they also require coordination of care and case management; they also need to access a variety of community resources; and they might require support for self-

management and self-efficacy. Health promotion/disease prevention programs, screening, and identification of risk at the primary care level can have an impact on the health and health care needs of all patients by decreasing the burden of disease and, in the long term, controlling health care costs. RNs and NPs, along with other members of interprofessional teams, have a vital role to play in achieving these goals.

Resources

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Additional reference material is available through the CARNA library.