HealthAffairsBlog

Primary Care Workforce: The Need To Remove Barriers For Nurse Practitioners And Physicians

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October 26, 2016

For the past four years, we have tracked primary care workforce numbers comparing the annual primary care residency match data with the primary care nurse practitioner (NP) graduation rates. While NP data continue to surge, the physician numbers, both allopathic and osteopathic, continue to be relatively disappointing, with only a minor increase.

With 20 million people now enrolled for health care coverage under the Patient Protection and Affordable Care Act, the need for primary care providers is swelling. The minimal increase in medical school graduates entering primary care does not address the prediction by the National Center for Health Workforce Analysis of shortages as high as 20,400 physicians by 2020.

Large increases in NP graduates each year are the good news in the midst of the inadequate numbers of physicians entering primary care. The challenge remains, though, to maximize the practice potential of physicians and NPs so that they both are practicing to the fullest extent of their education and training. Only then will the nation reap the full benefit of expanded access to quality primary care services and a reduction in unnecessary costs to the health care system.

2016 National Resident Matching Program Data

The data we have been reporting over the past four years continue to be striking. Although not a perfect comparison with NP primary care graduation rates, the primary care resident match data are the best we have. The National Resident Matching Program (NRMP) reports on both allopathic and osteopathic matches but does not differentiate between them in their detailed

data. Close to 14 percent of the U.S. matches in the NRMP report are graduates from osteopathic programs.

In 2014, NRMP data disclosed that there were merely 19 more U.S. resident matches to primary care specialties— family medicine, pediatrics, and internal medicine—than in 2013. In 2015, the numbers were up to 91 more U.S. residency primary care matches.

In 2016, U.S. NPRM family medicine matches numbered 58 more than in 2015. There were 13 more internal medicine matches than in 2015 and eight more pediatric primary care matches; this merely brought the pediatric match rate back up to where it was in 2013. In sum, in 2016 there were 2,044 U.S. medical student graduates matched to primary care specialties.

2016 American Osteopathic Association Match Data

In addition to the NRMP data, the American Osteopathic Association (AOA) reports their own match data, the Resident Registration Program. AOA's reported 2016 year one matches showed an increase in the match rate somewhat similar to 2016 NRMP data: 41 more family medicine U.S. osteopathic matches were reported than in 2015 (590 compared to 549). Osteopathic pediatric matches were up 14 from 2015 (65 compared to 51). Internal medicine numbers were not included as the AOA categories are different from the NRMP, making comparisons difficult.

The combined total of 2016 allopathic and osteopathic U.S. primary care matches was 2,699, up 144 over 2015. The osteopathic numbers may be underreported because of the internal medicine reporting issue.

When international graduates are included, the primary care match numbers for 2016 rise to 3,884 for allopathic matches and 1,060 for osteopathic matches, with an overall total of 4,944 primary care matches. Without the international match numbers, physician primary care numbers in the U.S. would be far more worrisome.

When considering the entire first year NRMP match numbers for *all* specialties—17,057—only 12 percent of those were for primary care specialties. That percent is only slightly greater than a year ago when it was 11.6 percent and back to what it was two years ago. For osteopathic U.S. graduates, using only the AOA data, the percent of U.S. positions matched to primary care represents a very different picture: Almost 30 percent (29 percent) of U.S. osteopathic total matches occur to primary care.

The osteopathic primary care match rate may actually be higher since the internal medicine osteopathic match data are not as clearly identified as the comparable NRMP data. Nevertheless, the lackluster overall increase to the primary care physician workforce offers little hope to significantly remedy the primary care provider shortage.

Primary Care Nurse Practitioner Graduation Rates

The story for primary care is much more positive when looking at the NP graduate numbers. The American Association of Colleges of Nursing and the National Organization of Nurse Practitioner Faculties recently reported that the number of 2015 primary care NP graduates (reported out in 2016) totaled 17,900, an increase of 3,500 over the previous year. These 17,900 primary care NP graduates represent 87 percent of the total 20,626 new NP graduates reported out this year. The NP increases have been consistent over the past five years and are expected to continue.

If one compares the percentage of NPs choosing primary care education (87 percent) to the 12 percent of U.S. NRMP residency matches choosing primary care and the 30 percent of U.S. AOA/osteopathic matches choosing primary care this year, the differences are stunning. Equally stunning is the 3,500 *increase* of NPs completing primary care programs, versus the addition of 144 more U.S. allopathic and osteopathic medical school graduate primary care matches.

This is compelling evidence that NPs have profound potential to address the enormous primary care needs in the country. Exhibit 1 gives a clear visual of the substantial and critical part of the

primary care workforce NP education has been providing for the past four years.

Three quarters of the NPs graduating in 2015 were family nurse practitioners — those prepared across the lifespan. The next largest group of graduates was represented by the adult-gerontology NP. About eight years ago, there was a national required change in the adult NP (the NP role that is congruent with primary care internal medicine in terms of age and focus) preparation requirements to include considerable educational emphasis on the older adult, given the U.S. demographics. Educational programs have undergone curriculum changes to include content that covers adolescents, adults, and older adults. In addition, the family NP programs also strengthened their inclusion of older adult content in the curriculum.

The most recent graduation numbers for the combined adult-gerontology NP was 2,847 or 16 percent of all primary care NP graduates. This fairly new emphasis on older adults holds enormous promise for addressing the primary care needs of that population.

The methodology we use in comparing the primary care practitioner numbers of physicians and NPs is not perfect, but it is the best that is currently available. NPs “match” to primary care when they enter a NP program. Not all NPs with primary care preparation end up in primary care, just as not all medical school graduates matched to primary care end up in primary care. Some start out in primary care and eventually may move to specialty practices over time. However, if even half or a third of NP primary care graduates practice long-term in primary care, these NPs will have a profound impact in addressing the shortage of providers.

What Does The Future Hold?

We believe that primary care is the foundation of a robust health care system. It will take all providers working to the fullest extent of their educational preparation to ensure an effective health care system that meets triple aim of improving the patient experience, improving the health of populations, and reducing the cost of care. However, costly and unnecessary barriers to NP practice continue to exist, impeding both NPs *and* physicians from working to their fullest capacity. The unnecessary requirements in numerous states for physicians to sign orders for physical therapy or other referrals, supervise NPs, or sign off on numerous other documents are costly, waste precious physician time, and are not feasible in the real world.

More than 20 million people are now enrolled in coverage under the ACA, and many of those are in Medicaid plans. Data indicate that NPs are more likely to care for Medicaid patients and to practice in rural areas than physicians. Regulations that support access to NPs are essential to fully meet this new demand.

There are now 21 states (42 percent) and the District of Columbia with full practice authority — that is, they allow NPs to practice fully under their own licenses without unnecessary requirements for physician supervision. Many other states have bills in their state legislatures attempting to move in that direction. Each year that we publish the resident match data and NP graduation rates, we ask: “How could the few additional primary care physicians (144 this year) ‘supervise’ or meet some state requirements for oversight of 3,500 new primary care NPs graduates?” Each new physician would need to be “supervising” 24 new NP graduates.

Not only is this absurd, but 10 states actually place limits on how many NPs a physician can legally oversee. For example, in Georgia, Alabama, and South Carolina, physicians can only supervise three to four NPs without an exemption or waiver. Other states (e.g. Florida) limit the number of practice sites in which a physician can supervise NPs.

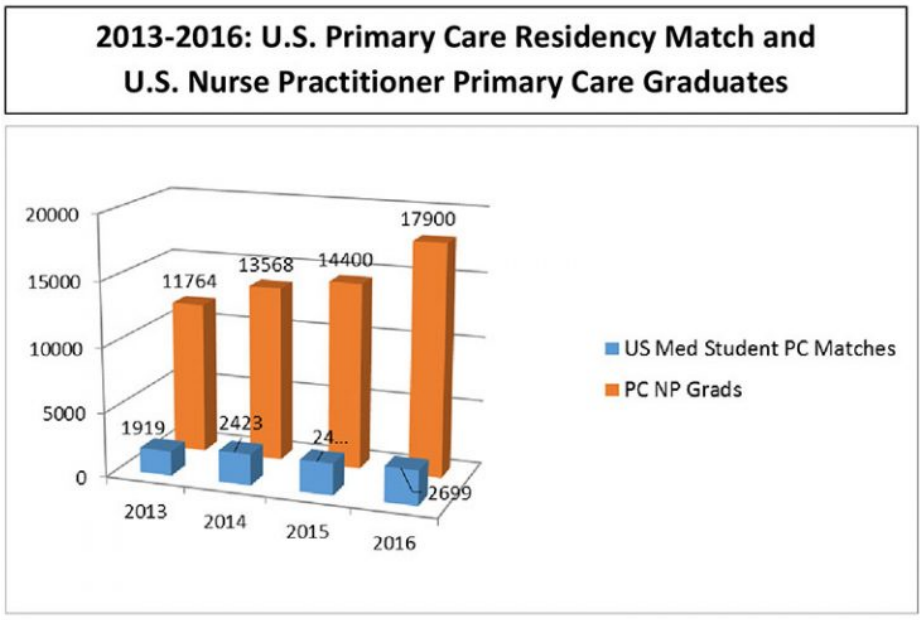
We are pleased to report this year a progressive move by the Veterans Administration (VA) to advance NP practice. The VA has a proposed rule to allow NPs and other advanced practice registered nurses to practice to the full scope of their education and training within the Veterans Health Administration. This also means more physicians in the VA can work to their full potential, unencumbered by unnecessary oversight policies.

Implementation of this as a final rule will increase access to quality care services for our nation's veterans and will be an important step towards removing unnecessary barriers to NP practice. The VA proposal is consistent with the recommendations of the Federal Trade Commission and other groups. The proposal has not gone without resistance, however: a record high number of public comments on the proposed rule once again reveal the divisiveness between the physician and nursing communities over supporting other health professionals in practicing to their full extent of preparation.

Indeed, in December 2015 the Committee for Assessing Progress on Implementing the Recommendations of the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* reported that, despite progress to remove scope of practice restrictions, opposition is pervasive. Yet the Committee also cited evidence that allowing all health professionals to practice to their full extent yields greater efficiency, quality, and provider satisfaction. This Committee has recommended that diverse stakeholders work together to build consensus around removing unnecessary scope of practice restrictions.

It is time to engage in a collaborative dialogue about the needed changes in the U.S. primary care health system. If we can better embrace models of team practice to promote strong patient and family centered care, we can move away from restrictive regulations and a silo approach to workforce development. The data show that physicians alone cannot meet the primary care needs of the nation, so discussion should no longer center on who should be doing it. Instead, our conversation needs to be on how we collectively build the primary care health workforce that best addresses what the patient needs.

Exhibit 1



ASSOCIATED TOPICS: HEALTH PROFESSIONALS, ORGANIZATION AND DELIVERY, QUALITY

TAGS: NURSE PRACTITIONERS, NURSES, PHYSICIANS, PRIMARY CARE, PRIMARY CARE WORKFORCE, RESIDENTS

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